MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a ★ 00666

Reg. Dist. No. 7730

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, Institution, or street address where death occurred:
128 Carroll Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 128 Carroll Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MARY POTTER ALDERMAN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: Allen W. Alderman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 5, 1878

8. AGE:

Years	Months	Days	If less than one day
68	10	8	..... hrs. ..... min.

9. Birthplace: Wattis, Michigan (Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business: Home

FATHER
12. Name: David Potter
13. Birthplace: Exeter, Michigan

MOTHER
14. Maiden name: Sarah Ann Keech
15. Birthplace: Michigan

16. Informant: Allen W. Alderman
Address: 128 Carroll Ave. Tak. Pk. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16, 1947. (month) (day) (year)
Cemetery or crematory: Udell Cemetery
Location: Belleville, Michigan (Wayne County)

18. Funeral director: Arthur Stalker
Address: 254 Carroll St. N.W. Takoma Park, D.C.

19. Jan 14 1947 (Date rec'd by registrar) J. Wilson Reed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/13/47, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/13/47, 19 47, to 1/13/47, 19 47
and that I last saw her alive on above date 19

Immediate cause of death	DURATION
Cerebral hemorrhage,	Began 11:30
Due to: Massive probably int ventricle	of death as above
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: 0
Date of op.
Autopsy results: 0
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas H. Holohan MD
Address: 500 Underwood St NW M. D. or other
Date signed: 1/13/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00667

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Jan. 8, 1947

Hospital, institution, or street address where death occurred:

Suburban Hosp., 8600 Old Georgetown Rd Bethesda Md.

How long in hospital or institution? since Jan. 8, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.R. #2 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ANKERS JONATHAN P. SR.

3.(b) Social Security Number 223-18-4654

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Olive Ankers

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1889

8. AGE: Years 57 | Months 5 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace Fairfax Virginia (Town, county and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER

12. Name Jonathan E. Ankers

13. Birthplace Virginia

MOTHER

14. Maiden name Ann Milstead

15. Birthplace Virginia

16. Informant Mr. George Robert Ankers

Address 2107 N. Rolfe St. Arlington Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/21/47 (month) (day) (year)

Cemetery or crematory Chestnut Grove Cemetery

Location Herndon, Virginia

18. Funeral director McKenrick Funeral Service

Address Bethesda, Maryland

19. 1/20 1947 (Date rec'd by registrar) M E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1947, at 10:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1944, to 1-18 1947

and that I last saw h. i. M. alive on 1-18 1947

	DURATION
Immediate cause of death Myocardial Cardio Vascular Disease	
Due to Cardiac Failure Obesity	3 weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. P. Andrews M.D. M.D. or other

Address 4201 Forrendon St. N.W. Date signed 1-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Copy

00668

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47c

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Sanitarium and Hospital

How long in hospital or institution? 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6505 Allegheny Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Mary Elizabeth Barrows

3.(b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed.

6.(b) Name of husband or wife ?

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) June ? 1884

8. AGE: Years 62 Months 6 Days — If less than one day ... hrs. ... min.

9. Birthplace Newcastle - England

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Robert Willey

13. Birthplace England.

MOTHER 14. Maiden name Jane Forset

15. Birthplace England.

16. Informant Washington Sanitarium Records

Address

17. Burial Date thereof Jan. 3-1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory George Wash. Mem.

Location Riggs Road - Hyattsville Md

18. Funeral director J. Arthur Walters

Address 254 Carroll Av. Takoma Park

19. Jan 2 1947 J. Wm. Dodd Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1, 1947, at 9:30 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/25/46 19... to 12/31/ 1946

and that I last saw her alive on 12/31/46 19...

	DURATION
Immediate cause of death Bronchogenic Cancer of lung [illegible]	
Due to Arteriosclerotic heart dis. c auricular fibrillation	
Due to Chronically [illegible]	
Other conditions [illegible]	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] H. Hobbs M. D. or other

Address 500 [illegible] NW Date signed 1/1/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00669

CERTIFICATE OF DEATH

Reg. Dist. No. 2140

1. PLACE OF DEATH:

County: Montgomery

City or town: Hollywood (Silver Spring)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Hollywood

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Hollywood, Silver Spring.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 2

3.(a) FULL NAME

EVERETT GUY BENNETT

3.(b) Social Security Number

214-03-9260

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: x

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 16th. 1900

8. AGE: Years	Months	Days	If less than one day
46	3	9	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: Waldo E. Bennett
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Ottie Copenhaver
15. Birthplace: W. Va.

16. Informant: Mrs. Waldo E. Bennett.,
Address: Hollywood, Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/28/47 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Bladensburg Rd. Pr. Geo's Co.,

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Maryland.

19. Jan 27 1947 (Date rec'd by Registrar) Josephine McShaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25 1947, at 11:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
Dep. Med. Exam case
and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION

Coronary occlusion — dead suddenly

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Brochart M.D.
Dep. Med. Exam. M. D. or other

Address: Gaithersburg, Md. Date signed 1-28-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

00670

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, institution, or street address where death occurred:
4519 Ridge St.
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4519 Ridge St. Chevy Chase, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME EDITH SELLMAN BEST

3. (b) Social Security Number None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Hezekiah Best deceased
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Aug. 1, 1874

8. AGE: Years	Months	Days	If less than one day
72	5	24	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Richard Parran Sellman
13. Birthplace Maryland

MOTHER
14. Maiden name Suan Witwright
15. Birthplace Maryland

16. Informant Alfred S. Best (Son)
Address 4519 Ridge St. Chevy Chase, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 1/27/47 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Suitland, Maryland

18. Funeral director Wm Reuben Pumphrey
Address 7557 Wis. Ave. Bethesda, Maryland

19. 1/27 19 47 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 19 47, at 8:45P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 19 47, to Jan 25 19 47
and that I last saw her alive on Jan 25 19 47

	Duration
Immediate cause of death: Cerebral Hemorrhage	7 Days
Due to: Hypertension	Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. M. D. or other
Address 8016 Georgetown Road Date signed 1/27/47

2-35

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00671 86

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One year +

Hospital, institution, or street address where death occurred: Wash. San. & Hospital

How long in hospital or institution? six days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Montgomery

City or town Takoma Park (If outside city or town limits, write RURAL and give nearest town)

Street No. 902 Houston Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harold Frederick Bohner

3.(b) Social Security Number

4. Sex M

5. Color or race Wh.

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) June 16, 1928

8. AGE: Years 18 Months 7 Days 0 If less than one day ... hrs. ... min.

9. Birthplace Union Springs, N.Y. (Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name Leonard F. Bohner

13. Birthplace Buffalo, New York.

MOTHER 14. Maiden name Margaret Fleming

15. Birthplace Battle Creek, Mich

16. Informant W. S. & Hosp. Records

Address

17. Burial Date thereof Jan. 17-1947 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ft Lincoln Cemetery

Location Bladensburg - Road

18. Funeral director J. Arthur Walter

Address 254 Carroll St. Wash. D.C.

19 Jan. 17 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16, 1947, at 8:54 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-10- 1947, to 1-16- 1947 and that I last saw him alive on 1-16- 1947

Immediate cause of death	DURATION
Bulbar Paralysis	2 days
Due to Ant. Poliomyelitis	9 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE Robert A Hare M.D. M. D. or other

Address Takoma Park, Md. Date signed 1/16/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

748 00672

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ years
Hospital, institution, or street address where death occurred:
4509 Winsor Lane
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4509 Windsor Lane
(If rural, give LOCATION)
2.(a) If veteren, neme wer: None

3.(a) FULL NAME: LINDA SUE BRACE

3.(b) Social Security Number: None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of huaband er wife: None

6.(c) If ativa, give age: -----

7. Birth date of deceaaed (mo., day, yr.): March 26, 1943

8. AGE:	Years	Months	Days	If less than one day
	3	8	12	-- hrs. -- min.

9. Birthplace: Tokoma Park, Maryland
(Town, county, and state)

10. Usuat occupation: None

11. Industry or busineaa: None

FATHER
12. Name: Wentworth Brace
13. Birthplace: Lewistown, Mo.

MOTHER
14. Maiden name: Edith M. Lawler
15. Birthplace: Rushville, Ill.

16. Informant: Mr. Wenthorth Brace (father)
Address: Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 11, 1947 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D.C.

18. Funeral director: W Reuben Tumey Jr
Address: Bethesda, Maryland

19. 1/9 1947 (Date rec'd by registrar) Mr E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8, 1947 at 8:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1946 to Death 1947 and that I laat saw h... alive on Jan. 7 1947

Immediate cause of death	DURATION
Acute Lymphatic Leukemia	about 1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. Francis Scalese M. D. or other
Address: 3547 Chesapeake St., N.W., Washington, D.C. Date signed: Jan. 8, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00673

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 hours

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 19 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Mass. County:

City or town: Lowell
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Richardson Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BROWN, James Walter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-7-22

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
24	9	29		

9. Birthplace: Lowell, Mass. (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER — 12. Name: James A. Brown

13. Birthplace: Mass.

MOTHER — 14. Maiden name: Catherine Gaffey

15. Birthplace: Ireland

16. Informant: Mother: Mrs. Catherine Brown

Address: 5 Richardson Avenue, Lowell, Mass.

17. burial (Burial, cremation, or removal. Which?) Date thereof 1-7-47 (month) (day) (year)

Cemetery or crematory: St. Patrick's Cemetery

Location: Lowell, Mass.

18. Funeral director: W. W. Chambers E.M.

Address: 1400 ChapinSt., N. W., Wash., D.C.

19. 1-6 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 19 47 at 1:42 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 January 19 47 to 6 Jan 19 47 and that I last saw h... im alive on 6 January 19 47

Immediate cause of death	DURATION
Inter-cranial hemorrhage	1 3/4 hrs.
Due to multiple fracture of skull (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 1-6-47

Where did injury occur? Arlington (City or town) Va (County) (State)

Injured at home, farm, industry, public place (where?): highway

Means of injury: auto Injured at work? no

23. SIGNATURE: Frank J. BROSCHART, M.D. Sig. med. Exam. (M. D. or other)

Address: Gaithersburg, Md. Date signed 1-6-47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1/11/47

2-25

2-2100 - 2-10

Evidence for the change of age isshown on G 108 2/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00674

61

Reg. Dist. No. 3160

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 5½ Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville (If outside city or town limits, write RURAL and give nearest town)
Street No. County Home (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard D. Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife
6.(c) If alive, give age yeers

7. Birth date of deceased (mo., day, yr.) May 27, 1893

8. AGE: Years	Months	Days	If less than one day
53 ~~54~~	7	23	hrs. min.

9. Birthplace Montgomery Co., Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Richard Dorsey
13. Birthplace Unknown

MOTHER
14. Maiden name Kate Brown
15. Birthplace Montgomery Co., Maryland

16. Informant Hospital Record.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof JAN 23, 1947 (month) (day) (year)
Cemetery or cremetory Church Cemetery
Location Mt. Zion, Maryland
18. Funeral director R.L. Snouffer
Address Rockville, Md.
19. 1-23-47 19 (Date rec'd by registrar) W.E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20, 1947 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18, 1947, to January 20, 1947, and that I last saw h.i.m. alive on January 20, 1947

Immediate cause of death	DURATION
Myocardial failure	6 days
Due to	
Due to	
Other conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Hypertrophy & dilatation of L. ventricle, chronic passive congestion of liver, spleen, kidneys, & adrenals
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Barbara Mauldin M.D. M. D. or other
Address Date signed

MARGIN RESERVED FOR BINDING. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15M

1-55-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940

00675

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:
9 Manor Circle,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Manor Circle
(If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME ROBERT RUTSEN LIVINGSTON BULLARD

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Rachel Louise Bullard

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) February 17, 1890

8. AGE:

Years	Months	Days	If less than one day
56	11	10	...hrs. ...min.

9. Birthplace Elizabeth town, New York
(Town, county, and state)

10. Usual occupation Civil Engineer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Ida Myers
15. Birthplace New York State

18. Informant Robert Edmund Bullard

Address 9 Manor Circle, Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof JAN. 24, 1947. (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Penna Ave Extended

18. Funeral director Arthur Walters

Address 254 Carroll St. N.W. Washington D.C.

19. Jan 22 1947 (Date rec'd by registrar) Wilmer Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 19 47 at 12:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 Med Exam Case 19 to 19

and that I last saw h... alive on 19

Immediate cause of death	DURATION
Coronary occlusion	about
Due to	suddenly
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Borchardt M.D.
Med Exam. M. D. or other

Address Takoma Park Md. Date signed 1-23-47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d ★ 00676

Reg. Diat. No. 2110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural - Near Purdum, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Montgomery

City or town: Rural - Near Purdum, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. - Clarksburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Luther Melvin Burdette

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Widowed

6.(b) Name of ~~husband~~ or wife: Effie Davis Burdette

6.(c) If alive, give age: ~~Oct.~~ years

7. Birth date of deceased (mo., day, yr.): ~~Nov.~~ 8. 1875.

8. AGE:

Years	Months	Days	If less than one day
71	2	23	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired farmer

11. Industry or business: Farm.

FATHER

12. Name: Rev. L. J. Burdette

13. Birthplace: Maryland.

MOTHER

14. Maiden name: Roberta King.

15. Birthplace: Maryland

16. Informant: Herbert Burdette

Address: Clarksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 4 1947 (month) (day) (year)

Cemetery or crematory: Bethesda Mem.

Location: Brookeville, Md.

18. Funeral director: J. B. Beall, Inc.

Address: Damascus, Md.

19. Jan 1 1947 (Date rec'd by registrar) Wells N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1, 1947, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 15, 1943, to January 1, 1947 and that I last saw him alive on July 6, 1946.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	6 hours
Due to: Arteriosclerotic cardiovascular disease.	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D. M. D. or other

Address: Damascus, Md. Date signed: 1/1/47.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00677

1318

CERTIFICATE OF DEATH

Reg. Dist. No. 7-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Wheaton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3.2 years

Hospital, institution, or street address where death occurred: none

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Wheaton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Thomas Burgess

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Married

6.(b) Name of husband or wife: Margetta Burgess

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): June 15 1865

8. AGE: Years	Months	Days	If less than one day
81 yrs	6		— hrs. — min.

9. Birthplace: (Town, county, and state)

10. Usual occupation: Un employed

11. Industry or business

FATHER 12. Name: Daniel Burgess

13. Birthplace: unknown

MOTHER 14. Maiden name: Mary Burgess

15. Birthplace: unknown

16. Informant: Mrs Mary Etta Burgess

Address: Wheaton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 15, 1947 (month) (day) (year)

Cemetery or crematory: Lincoln Memorial

Location: Arlington Va

18. Funeral director: Wimert Farms Co

Address: 1432 Jonquil St. N.W. Wash. D.C.

19. Jan 17 1947 (Date rec'd by registrar) Joaphine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 11 1947, at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1947, to Jan 11 1947

and that I last saw h-him alive on Jan 9 1947

Immediate cause of death	DURATION
Chronic Myocarditis	2 yrs
Due to: Chronic Nephritis	5 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Calvin B. LeCompte M. D. or other

Address: Wheaton Md Date signed: 1/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940 ★ 00678

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co,

City or town: Clarksburg Md,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Clarksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: EVERETT LINDEN CECIL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	SINGLE

6.(b) Name of husband or wife: If

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2. 1891

8. AGE: Years	Months	Days	If less than one day
55	8	9	hrs. min.

9. Birthplace: Clarksburg Md

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: If

FATHER 12. Name: Everett N Cecil

13. Birthplace: Md

MOTHER 14. Maiden name: Julia M. Thompson

15. Birthplace: Md

16. Informant: Mrs. Laura Walker

Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/13/47 (month) (day) (year)

Cemetery or crematory: Kyattstown Cemetery

Location: Kyattstown Md,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md,

19: Jan 13 1947 Ethel A Cate Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1 19 47, at 3:00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 Med. 19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	Four days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Bouchat M.D. M. D. or other

Address: Gaithersburg Md. Date signed 1-14-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

00679

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2months, 29 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2909 29th St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CHANDLER, Lloyd Horwitz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Agatha Chandler
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 17, 1869

8. AGE: Years	Months	Days	If less than one day
77	5	0	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Retired Navy
11. Industry or business:

FATHER
12. Name: William E. Chandler dec.
13. Birthplace: N.H.

MOTHER
14. Maiden name: Catherine Gilmore, dec.
15. Birthplace: N.H.

16. Informant: Wife: Mrs. Agatha Chandler
Address: 2909 29th St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-20-47 (month) (day) (year)
Cemetery or crematory: Glenwood Cemetery
Location: Washington, D. C.

18. Funeral director: Joseph Gawler Sons R.F.N.
Address: 1756 Penn., Avenue, N.W., Wash., D.C.

19. 1-17, 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 January, 19 47, at 4:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 October 1946 to Jan 17 1947 and that I last saw him alive on 17 Jan 1947

Immediate cause of death: Congestive heart failure — DURATION:

Due to: Arteriosclerotic heart disease & old & recent myocardial infarcts

Due to: Arteriosclerosis, generalized

Other conditions: Bronchopneumonia

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. B. Shuler
J. B. SHULER, Comdr. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 1-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1/21/47

1-25

2-2160-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 b

00680

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:
137 Glen Brook Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 137 Glen Brook Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: ARTHUR D. CHESLEY

3. (b) Social Security Number: 577-24-3968

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Anna Barnes Chesley
deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 25, 1869

8. AGE: Years	Months	Days	If less than one day
77	10	25	..... hrs. ..... min.

9. Birthplace: Campbellsport, Wisconsin
(Town, county, and state)

10. Usual occupation: Farmer- Retired

11. Industry or business

FATHER
12. Name: Israel Chesley
13. Birthplace: Nova Scotia Canada

MOTHER
14. Maiden name: Jemima Hendricks
15. Birthplace: Penna.

16. Informant: Mrs. Mary Eisele
Address: Daughter- 137 Glen Brook Rd.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 1/21/47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Maryland

18. Funeral director: W. Reuben Cunningham

Address: Bethesda, Maryland

19. 1/20 19 47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20, 1947 at 6:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 August 1946, to January 1947 and that I last saw him alive on 17 January 1947

Immediate cause of death	DURATION
Starvation	6 mo.
Due to Carcinoma of pylorus and of stomach	1 yr.
Due to	
Other conditions none.	

(Include pregnancy within 3 months of death)

Major findings of operations: none. Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John D. Ball M. D. or other

Address: 7956 Hampton Rd. Bell. Md. Date signed: 20 Jan. 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48 b

00681

CERTIFICATE OF DEATH

Reg. Dist. No. 2130

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville (Sanitarium)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 years

Hospital, Institution, or street address where death occurred: Norbeck Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: CARRIE ENGLAND CLARK

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm. D. Clark

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Sept 13th 1882

8. AGE: Years	Months	Days	If less than one day
58	4	1	hrs. min.

9. Birthplace: Rockville, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John G. England

13. Birthplace: Rockville, Maryland

MOTHER — 14. Maiden name: Annie Griffith

15. Birthplace: Montg. Co. Md.

16. Informant: Mr. Wm. D. Clark

Address: Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16/47 (month) (day) (year)

Cemetery or crematory: Rockville Union Cemetery

Location: Rockville, Maryland

18. Funeral director: W. Reuben Thompson

Address: Rockville, Maryland

19. 1-14-1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14 1947, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946, to Jan. 14 1947

and that I last saw h[illegible] alive on January 13 1947

Immediate cause of death: Carcinoma of uterus — DURATION: 27 months

Due to: —

Due to: —

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: Biopsy + radium applications, Date of op. 1945

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Wm. P. Smithers M.D. M. D. or other

Address: Rockville, Md. Date signed 1/14/47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00682

92d

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: MR. WILLIAM HENRY COLEMAN

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Warnetta B. Coleman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8, 1875

8. AGE: Years	Months	Days	If less than one day
71	5	29	hrs. min.

8. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired- B. & O. R. R.

11. Industry or business

FATHER — 12. Name: William Henry Coleman

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Anne S. Coleman

MOTHER — 15. Birthplace: Maryland

16. Informant: Mr. Ben Coleman, Son

Address: Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/10/46 (month) (day) (year)

Cemetery or crematory: Darnestown Cemetery

Location: Darnestown, Maryland

18. Funeral director: W Reuben Tumphrey

Address: Rockville, Maryland

19. 1-9 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7, 1947 at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to January 7 1947 and that I last saw h[illegible] alive on Jan. 7 1947

Immediate cause of death	DURATION
Chronic valvular heart disease	several years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: G. V. Hartley M.D.
M. D. or other

Address: Rockville, Md. Date signed: 1/9/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

CC683

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59-F)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Montgomery Gen'l
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: Rockville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Clara Francis Cooper

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 8 1858

8. AGE: Years: 88 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Oswego N Y
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: ?

MOTHER
14. Maiden name: Unknown
15. Birthplace: ?

16. Informant: Miss Emma Castella
Address: 15 E St N W

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan 10 1947 (month) (day) (year)
Cemetery or crematory: Washington D C
Location:

18. Funeral director: Deal Funeral Home
Address: 4812 Georgia Ave N W

19. 1/10 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1947, at 1 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943, to Jan 1947
and that I last saw h alive on Jan 9 1947

Immediate cause of death	DURATION
Myocardial failure	2 days
Due to: Arteriosclerosis	10 years
Due to: Convulsive seizures 870	1 yrs.
Chronic arthritis	4 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wm P. Smithmeyer M.D.
M. D. or other
Address: Rockville Md. Date signed 1/10/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

00684

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County: Montgomery

City or town: Tokoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, Institution, or street address where death occurred:
Washington Sanitarium Hospital

How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Garrett Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Strathmore Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

(CRIST) HOWARD PRESTON CRIST

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Myrtie B. Crist

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 17, 1872

8. AGE: Years	Months	Days	If less than one day
74	4	10	..... hrs. ..... min.

9. Birthplace: Augusta Co. Virginia
(Town, county, and state)

10. Usual occupation: Cabinet Maker

11. Industry or business:

FATHER
12. Name: Henry Crist
13. Birthplace: Virginia

MOTHER
14. Maiden name: Barbara Karrikoof
15. Birthplace: Virginia

16. Informant: Records Washington San. & Hosp.
Address: Tokoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/29/47 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Bethesda, Maryland

18. Funeral director: W. Reuben Trundle

Address: 7557 Wis. Ave. Bethesda, Maryland

19. Jan. 27 1947 (Date rec'd by registrar) F. Wilmer Dell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/27/47, 1930 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/47 to 1/27/47 and that I last saw him alive on 1/26/47

	DURATION
Immediate cause of death: (a) Hemorrhage, cerebral; (b) Uremia;	27 days
Due to: Arteriosclerosis; Generalized; severe; & Cerebral Contusion; Severe	years (10-20)
Due to:	
Other conditions: Hypertension; moderate	years (5-10)

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Samuel Allen M. D. or other

Address: Kensington, Md. Date signed: 1/27/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

Evidence for the change of age is shown on G 108 1/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00685

Reg. Dist. No. 2130

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months
Hospital, institution, or street address where death occurred:
406 Reading Avenue,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 406 Reading Avenue,
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME George Wilbert Cronise
G. W. Cronise

3.(b) Social Security Number 212-10-3944

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Catherine Cronise
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): August 28, 1883

8. AGE: Years	Months	Days	If less than one day
63	6	15	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: Hanson M. Cronise
13. Birthplace: Virginia

MOTHER
14. Maiden name: Laura Bruebaker
15. Birthplace: Virginia

16. Informant: Mrs. Mary C. Cronise
Address: Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/47 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director: W. Reuben Pumphrey
Address: Rockville, Maryland

19. 1-14-47 (Date rec'd by registrar)
Betty Jane Snyder
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13 1947, at 5 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1946, to Jan 13 1947
and that I last saw h[illegible] alive on Jan 10 1947

Immediate cause of death	DURATION
Hemiplegia	
Due to	
Due to arteriosclerosis	
Other conditions	
Senile Dementia.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Gaithersburg Date signed: Jan 13 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

106b

* 00686

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, Institution, or street address where death occurred:
1703 Dennis Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1703 Dennis Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME CORBIN CENTRAL CROTTS

3. (b) Social Security Number 577-05-2978

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Grace Vena

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 18th. 1892

8. AGE: Years	Months	Days	If less than one day
54	10	1	..... hrs. ..... min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual occupation Brickmason

11. Industry or business

FATHER 12. Name James M. Crotts

13. Birthplace N. C.

MOTHER 14. Maiden name Liza Jane Louis

15. Birthplace N. C.

16. Informant Mrs. Grace V. Crotts (wife)

Address 1703 Dennis Ave. Silver Spg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-22-1947 (month) (day) (year)

Cemetery or crematory Colesville Methodist Church

Location Colesville, Montg. Co. Md.

16. Funeral director James E. Pumphrey

Address Silver Spring, Md.

19. Jan. 21 1947 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 1947 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 25 1943 to Jan. 19 1947 and that I last saw him alive on Jan. 19 1947

Immediate cause of death	DURATION
Bronchial Asthma,	18+ yrs.
with Bronchiectasis	
Due to 106b	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE H. F. McNeil, M.D.
M. D. or other

Address Silver Spring, Md. Date signed 1/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117a

00687

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 hours

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 13 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)

Street No. 40 Fairhaven Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: DELLEVIE, John (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Bertha Dellevie

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 10 July 1900

8. AGE: Years	Months	Days	If less than one day
46	5	22	____ hrs. ____ min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Clerk in Adj.Gen.Office

11. Industry or business: civil service

FATHER
12. Name: John Dellevie (deceased)
13. Birthplace: Va.

MOTHER
14. Maiden name: Sadie Peterson
15. Birthplace: Va. (deceased)

16. Informant: Wife: Mrs. Bertha Delleive
Address: 40 Fairhaven Avenue, Alexandria, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof 1-4-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 1-2 (Date rec'd by registrar) 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 January 19 47 at 9:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1- 19 47, to 1-2 19 47 and that I last saw him alive on 1-2- 19 47

Immediate cause of death	DURATION
General Peritonitis (Hemorrhage)	36 hrs
Due to: Perforated, Hemorrhagic marginal ulcer	2 hrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Perforation Jejunum (marginal ulcer) General Peritonitis Date of op. 1/2/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. A. Murphy.
J. A. MURPHY, Comdr.(MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 1-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/11/47

2-25

2-2160- 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 b

00688 Reg. Dist. No. 216 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1/24/47

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 424 "O" Street, NW
(If rural, give LOCATION)

2.(a) If veteran, name war 1st WW

3.(a) FULL NAME

DICKS, John Henry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife Mrs. Willie Mae Dicks

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 20 February 1895

8. AGE: Years	Months	Days	If less than one day
51	10	30	..... hrs. ..... min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business

FATHER
12. Name Hampton Dicks
13. Birthplace South Carolina

MOTHER
14. Maiden name Laura Shapp
15. Birthplace South Carolina

16. Informant Mrs. Willie Mae Dicks

Address 424 "O" St., NW, Washington, D. C.

17. burial Date thereof 1-24-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zine Fair Cemetery

Location Wiliston, South Carolina

18. Funeral director Ernest W. Jarvis L.H.

Address 1432 U St., N. W., Wash., D.C.

19. 1-19- 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 January 1947, 3:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-3- 1947, to 1-19- 1947 and that I last saw him alive on 1-19 1947

Immediate cause of death	DURATION
Bronchopneumonia	1 wks
Due to uremia	2 wks
Due to chronic nephritis	6 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results Systemic Bronchopneumonia, chronic nephritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. L. Fleck R.L.FLECK LT MC USN
M. D. or other

Address USNH Bethesda, Md. Date signed 1-19-47

2-25

2-22400 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108 00689

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:

USNH Bethesda, Md.

How long in hospital or Institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County United States

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 K St., S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME DORSEY, JOSEPH (N) VAP

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	Col-US	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 24 1919

8. AGE:

Years	Months	Days	If less than one day
27	7	17	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business

FATHER 12. Name Roube Dorsey

13. Birthplace Maryland

MOTHER 14. Maiden name Angeline ?

15. Birthplace Maryland

16. Informant Grandmother: Mrs. Jennie Diggs

Address 207 K St. S.E. WASH. D.C.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 1-14-47 (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington Virginia

18. Funeral director E. FORD E. Ford

Address 1214 4th St. S.W. WASH. D.C.

19. 1-11 (Date rec'd by registrar) 1947 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 January 19 46 47 at 3:30P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3 Jan 1947 to 11 Jan 1947

and that I last saw him alive on 11 January 1947

	DURATION
Immediate cause of death Lobar Pneumonia	5 days
Due to There was acute glomerular nephritis	
Due to with Edema, congestive	
Other conditions failure and uremia	3 wks

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C.W. Thompson C.W. THOMPSON Lt.CDR (MC) USN
M. D. or other

Address USNH Bethesda, Md. Date signed 1-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1/18/47

2-25

2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 175a

CERTIFICATE OF DEATH

00690

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Monty.

City or town Olney Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Mont. Co. General Hos.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Howard

City or town Simpsonville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter L Dorsey

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	married

6.(b) Name of husband or wife Mary E Dorsey.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 10, 1893

8. AGE:	Years	Months	Days	If less than one day
	53	9	3	..... hrs. ..... min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual occupation Farm Laborer

11. Industry or business

MOTHER FATHER

12. Name Emma Dorsey

13. Birthplace Md.

MOTHER

14. Maiden name Alice Carter

15. Birthplace Md.

16. Informant Mary Dorsey.

Address Simpsonville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-17-47 (month) (day) (year)

Cemetery or crematory Locust Chapel

Location Ellicott City Md.

18. Funeral director F. C. Higinbothom

Address Ellicott City Md.

19. 1-17-1947 (Date rec'd by registrar) Gertrude B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13 1947, at 5 05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9 1947 to January 13 1947 and that I last saw him alive on January 13 1947

Immediate cause of death	DURATION
Intracranial hemorrhage	4 days
Due to: Cerebral concussion	4 days
Due to:	
Other conditions: Arterial hypertension	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: hemorrhage into 3rd ventricle

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1/9/47

Where did injury occur? Simpsonville, Howard, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) farm

Means of injury fell off wagon Injured at work? yes

23. SIGNATURE Charles S. Whitaker M.D.
M. D. or other

Address Clarksville, Md Date signed 1/15/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00691

126

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give resideoce of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1373 Nicholson Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DOUSE, Helen (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: William Douse

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 20 March 1876

8. AGE: Years	Months	Days	If less than one day
70	9	16	..... hrs. ..... min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: John Germand dec.

13. Birthplace: England

MOTHER — 14. Maiden name: Susan Edwards dec.

15. Birthplace: England

16. Informant: son: Sgt. Kenneth Douse, USMC

Address: 1373 Nicholson St., Wash., D.C.

17. cremation (Burial, cremation, or removal. Which?) Date thereof 1-7-47 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: Washington, D. C.

18. Funeral director: W. W. CHAMBERS (R&m)

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 1-7 19 47 Mary Charlotte Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 January 1947, at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 January 1947, to 6 January 1947

and that I last saw h... im alive on 6 January 1947

Immediate cause of death: Intestinal obstruction of jejunum due to large gallstone — DURATION: 4 days

Due to: cholecystitis and cholelithiasis — DURATION: indef.

Due to: cholecystenterostomy. — DURATION: indef.

Other conditions: Uremia, Bronchopneumonia

(Include pregnancy within 3 months of death)

Major findings of operations: no operation

Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. C. OWENS, Lt. Cdr. (MC) USNR (M. D. or other)

Address: USNH Bethesda, Md. Date signed 1-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1/24/47

2-25-

2-72160 — 2-10

00692

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos 20 days
Hospital, institution, or street address where death occurred:
2 mos. 20 days
How long in hospital or institution? USNH, Bethesda, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 Raleigh Street, SE
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: EATON, Kenneth Humphrey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mildred Ann Eaton
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 17, 1909

8. AGE: Years	Months	Days	If less than one day
37	0	19	hrs. min.

9. Birthplace: Barker, New York (Town, county, and state)
10. Usual occupation: Naval Service
11. Industry or business: U. S. Navy
FATHER 12. Name: Leslie Eaton
13. Birthplace: Barker, New York
MOTHER 14. Maiden name: Meredith Humphrey
15. Birthplace: Barker, New York
16. Informant: Wife: Mildred Ann Eaton
Address: 312 Raleigh St. SE, Washington, D. C.
17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-8-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia
18. Funeral director: W.W.Chambers Rs.m.
Address: 517 11th St. SE, Washington, D.C.
19. 1-5- 1947 Mary Charlotte Smith (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 January 1947, at 3:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 16 1946, to 5 January 1947 and that I last saw him alive on 5 January 1947

	DURATION
Immediate cause of death: Adeno Carcinoma of Pancreas	2 mo
Due to:	
Due to:	
Other conditions: obstructive Jaundice	2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations: adenocarcinoma of Pancreas Metastasis to liver and peritoneum Date of op. 12/28/46
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?
23. SIGNATURE: L. G. Bell, Capt. MC USNR (M. D. or other)
Address: USNH Bethesda, Md. Date signed: 1-5-47

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15M

1/16/47

2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

00693

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred:
6201 - Brookville, Rd.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6201 - Brookville Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah Flack

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Seperated

6.(b) Name of husband or wife Charles Flack.
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1877

8. AGE: Years 71 | Months 4 | Days 0 | If less than one day ..... hrs. ..... min.

9. Birthplace Manchester England
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Charles Brennan
13. Birthplace England

MOTHER
14. Maiden name Eliz Jacobs.
15. Birthplace England.

16. Informant John C. Flack.
Address 6201 - Brookeville Rd. Ch. Ch. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/7/47 (month) (day) (year)
Cemetery or crematory Nash. Natl Cem
Location Nash DC
18. Funeral director W. W. CHAMBERS CO
Address WASHINGTON, D.C.

19. 1/4 (Date rec'd by registrar) 1947 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1947, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1945, to Jan 4 1947
and that I last saw h.. alive on Dec. 13 1946

Immediate cause of death	DURATION
Generalized Carcinomatosis (Ant.)	3 yrs
Due to Primary in gastro-intestinal tract — the ascending colon. Cert.	
Due to	
Other conditions Toxemia	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE H. Weinstein M. D. or other
Address 3311 - 16 - NW Date signed 1/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

00694

Reg. Diat. No. 22-3-1

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:
805 Maple Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10320 Old Bladensburg Road
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: JOSEPH W. FLEMING

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ wife: Bessie Howard

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 15th. 1865

8. AGE: Years	Months	Days	If less than one day
81	11	18	..... hrs. ..... min.

9. Birthplace: Williamsport, Maryland
(Town, county, and state)

10. Usual occupation: Leather expert

11. Industry or business:

FATHER
12. Name: John A. Fleming
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Wolf
15. Birthplace: Maryland

16. Informant: Mrs. Bessie H. Fleming
Address: 10320 Old Bladensburg Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-6-1947 (month) (day) (year)
Cemetery or crematory: Riverview Cemetery
Location: Williamsport, Wash. Co. Md.

18. Funeral director: Warren Dunkley
Address: Silver Spring, Md.

19. Jan 4 1947 (Date rec'd by registrar) J. W. Dudley Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 Jan 1947 at 8.05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Dec 1947 to 3 Jan 1947 and that I last saw h... alive on 3 Jan 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage	1 wk.
Due to: Hypertension	—
Generalized arteriosclerosis	—
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: William D. Reed, M.D.
M. D. or other

Address: Silver Spring Md. Date signed: 3 Jan 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-25

2-2280 — 1-10

Evidence for approx. age is shown on G 109 3/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

#6d

00695

Reg. Diat. No. 2180

1. PLACE OF DEATH:
County MONTGOMERY COUNTY
City or town BOYDS, STATION MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY
City or town BOYD'S STATION
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD #2 BOX #40
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME HARRISON HENERY FOLLIN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of ~~husband~~ or wife IDA FOLLIN, (NEE) CHAMBLAIN 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years Approx 60 | Months Unknown | Days | If less than one day ..... hrs. ..... min.

9. Birthplace LOUDEN CO. VIRGINIA (Town, county, and state)

10. Usual occupation FARMER

11. Industry or business

FATHER 12. Name GEORGE FOLLIN
13. Birthplace LOUDEN, CO. VIRGINIA

MOTHER 14. Maiden name Lucy Akers
15. Birthplace Loudon Co. Va

16. Informant Mrs. Louise Shares
Address 124 Oath St. NE. Wash. D C

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 24 1947 (month) (day) (year)
Cemetery or crematory Washington Nat. Cemetery
Location Washington D C

18. Funeral director W.W. Chamblin Co.
Address 3072 M St. NW Washington DC

19. Jan. 21 1947 Alvada L. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1947, at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept Med. Exam case 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Carcinoma of rectum	10 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Fred J. Bonfoot M.D.
Med. Examr. M. D. or other
Address Hagerstown md Date signed 1-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

00696

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montg. Co.

City or town: Gaithersburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3yr 2Mo 13Da

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 3yr 2Mo 13 Da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montg

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Phebe Ann Froder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(o) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Froder

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 23rd 1862

8. AGE:	Years	Months	Days	If less than one day
1862	84	3	26	..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: Joshua Vint

13. Birthplace: W, Va.

MOTHER — 14. Maiden name: Kerdenia Solmon

15. Birthplace: Miss,

16. Informant: Methodist Home, M. M. Wilson

Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/21/47 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg Md,

18. Funeral director: Ernest C. Gaither

Address: Gaithersburg Md.

19. Jan. 20 1947 (Date rec'd by registrar) Alfreda L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 19th 1947 at 9.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.47 to Jan - 19 - 1947 and that I last saw h[illegible] alive on Jan - 16 - 1947

Immediate cause of death	DURATION
Senile Insanities	2-4 yrs
Due to: Cardio - nephritis	4 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: William L. Mills, M.D. M. D. or other

Address: Gaithersburg, Md. Date signed 1-20-47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

47c

06697

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2/7/47

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? seven days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? seven days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Fla. County:
City or town: Pensacola
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rosemont
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GEIGER, Roy Stanley. Lt. General USMC

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Catherine Eunice Geiger
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 25 January 1885

8. AGE: Years	Months	Days	If less than one day
61	11	28	hrs. min.

9. Birthplace: Florida (Town, county, and state)
10. Usual occupation: Marine Corps
11. Industry or business:
FATHER 12. Name: Marion Geiger
13. Birthplace: Fla.
MOTHER 14. Maiden name: Josephine Prevatt
15. Birthplace: Fla.
16. Informant: wife: Mrs. Eunice Geiger
Address: Qtrs. 4, Marine Bks., 8th & I St., S.E. Washington, D. C.
17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-25-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., N. W., Wash., D.C.
19. Jan 23 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 January 1947 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 January 1947, to 23 January 1947, and that I last saw him alive on 23 January 1947

Immediate cause of death	DURATION
Carcinoma, Bronchogenic with metastasis to liver, lungs, adrenals, bone marrow, lymph nodes & liver failure	
Due to:	
Due to:	
Other conditions: Organizing thrombus of left pulmonary artery with infarction of lower lobe of left lung. None	

(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.:
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L. G. BELL, Captain (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 1-23-47

2-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

9020 930 00698 Reg. Dist. No. 2160

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6000 Wedeln Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Wallace E. Gregg

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Jennie
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov-19, 1876-

8. AGE: Years	Months	Days	If less than one day
70	2	7	..... hrs. ..... min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: John W. Gregg
13. Birthplace: ?
MOTHER 14. Maiden name: Charlotte Ward
15. Birthplace: Plainfield, N.J.
16. Informant: Mrs. Bessie O'Reilly
Address: 1516 Rhodes St. Arlington Va.
17. (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington D.C.
18. Funeral director: The S.H. Hines Co
Address: 2901 14th. St. N.W.
19. 1/26 1947 Wm E Forbes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan-26, 1947, at 2:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1947, to Jan 26 1947
and that I last saw him alive on Jan 26 1947
Immediate cause of death: (1) Congestive heart failure, (2) Coronary sclerosis (3) acute fibrinous pericarditis

DURATION	
(1)	9 days
(2)	7 years
(3)	5 days
	2 years

Due to: generalized arteriosclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: ..... Date of op. .....
Autopsy results: Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Edw Kelan MD
M. D. or other
Address: 6001 Nevada Ave NW Date signed: Jan 26-1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

Evidence for the change of age is shown on G 108 1/17/47

94a 06699

83a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 609 9th St., S.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st WW

3.(a) FULL NAME: HAAS, Raymond (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5 October 1892

8. AGE: Years	Months	Days	If less than one day
54 55/	3	0	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business: unknown

FATHER
12. Name: George Haas
13. Birthplace: N.Y. (dec)

MOTHER
14. Maiden name: Eva Turley
15. Birthplace: Va. (dec)

16. Informant: Son: Mr. Austin Haas
Address: 609 9th St., S.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 1-8-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W.W.Chambers R.S.m.

Address: 517 11th St. SE, Washington, D. C.

19. 1-5 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 January 1947, at 2:56 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 January 1947, to 5 January 1947 and that I last saw h... im alive on 5 January 1947

	DURATION
Immediate cause of death: Bronchopneumonia	5 days
Due to: Cerebral Thrombosis & cerebral hemorrhage	4 days
Due to: Hypertension	years
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. W. Thompson C. W. THOMPSON, Lt.Cdr.(MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; 1 is especially important. Physicians: please write the causes of death clearly and legibly.

VS A6 9-45-15M 1/11/47

2-25

2160- 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462 ★ 06700

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Res. or street address where death occurred:
9221 Old Bladensburg Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9221 Old Bladensburg Road
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: HELEN A. HART

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: William F.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 1st. 1866

8. AGE: Years	Months	Days	If less than one day
80	4	9	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER — 12. Name: Lewis G. Stephens

13. Birthplace: England

MOTHER — 14. Maiden name: Caroline M. Wall

15. Birthplace: Baltimore, Md.

16. Informant: Mr. Lewis S. Hart (son)

Address: 9221 Old Bladensburg Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-13-1947 (month) (day) (year)

Cemetery or crematory: Glenwood

Location: Washington, D. C.

18. Funeral director: Wame & Pumphrey

Address: Silver Spring, Md.

19. Jan 10 1947 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 10 1947, at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Jany 9 1947 and that I last saw her alive on Jany 9 1947

Immediate cause of death	DURATION
Carcinoma of colon	Six mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... injured at work?

23. SIGNATURE: John N. Andrews M.D. M. D. or other

Address: 960 Colesville Rd Silver Spring, Md. Date signed 1-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122a

00701

CERTIFICATE OF DEATH

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred: Montgomery Gen Hosp
How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rural Clarksburg Rte 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Ernest Hawkins ~~Ernest Hawkins~~

3.(b) Social Security Number: non

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife: Eva Hawkins
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Apr 29 1885

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
61	9	2		

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Stationary Operator
11. Industry or business:
FATHER 12. Name: John Hawkins
13. Birthplace: Md
MOTHER 14. Maiden name: Annie Thompson
15. Birthplace: Md
16. Informant: Ernest Farley Jr.
Address: Rockville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2 1947 (month) (day) (year)
Cemetery or crematory: Boyds Md
Location: Montgomery Co
18. Funeral director: Roy W Barber
Address: Laytonsville Md
19. 9-2-47 (Date rec'd by registrar) 19.47 Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/31/1947, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/12/1947 to 1/31/1947 and that I last saw h... alive on 1/30/1947

Immediate cause of death	DURATION
Pulmonary Tbc -	18 mos
Due to: Hemorrhage Bilateral	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op. 1/13/47

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Sandy Spring Md Date signed: 1/31/47

1735

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00702

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: KENSINGTON.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, institution, or~~ street address where death occurred:

28 ST PAUL ST.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: KENSINGTON
(If outside city or town limits, write RURAL and give nearest town)

Street No. 25. ST PAUL ST.
(If rural, give LOCATION)

2.(a) If veteran, name war: NO.

3.(a) FULL NAME: JOSEPH CHARLES HAWKINS

3.(b) Social Security Number: NONE.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	DIVORCED

6.(b) Name of ~~husband or~~ wife: ROSIE DAY

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): JULY 15 - 1861.

8. AGE: Years	Months	Days	If less than one day
85	5	26.	..... hrs. ..... min.

9. Birthplace: MONTGOMERY Co - MD
(Town, county, and state)

10. Usual occupation: RETIRED FARMER.

11. Industry or business

FATHER 12. Name: JOHN T HAWKINS

13. Birthplace: MONTG. CO. MD.

MOTHER 14. Maiden name: ANNIE ELIZABETH THOMPSON.

15. Birthplace: MONTG. CO. MD

16. Informant: MRS. FRANK SHIPLEY (DAUGHTER).

Address: 28 ST PAUL ST. KENSINGTON - MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 1 - 14 - 1947. (month) (day) (year)

Cemetery or ~~crematory~~: MONOCACY

Location: BEALLSVILLE - MONTG. CO - MD

18. Funeral director: Warner & Pumphrey.

Address: SILVER SPRING - MD

19. Jan 13 1947 (Date rec'd by registrar) Josephine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 11 1947, at 10:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dept med. Exam 1947 to ..... 19.....

and that I last saw h..... alive on ..... 18.....

Immediate cause of death	DURATION
Coronary occlusion	dur. sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

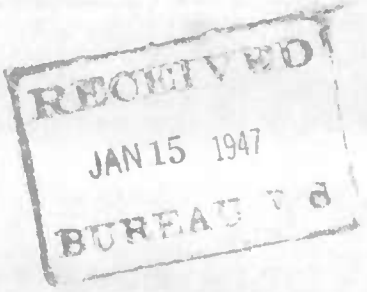
23. SIGNATURE: Frank J. Brockhart M.D. Dept. Med. Exam. M. D. or other

Address: Gaithersburg md Date signed: 1-12-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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06703

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 5084

1. PLACE OF DEATH:

County: Montgomery

City or town: Kensington (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington (If outside city or town limits, write RURAL and give nearest town)

Street No. 10211 Conn. Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Harvey Wilmer Hawthorne

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nelle P. Hawthorne

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Jan. 28, 1875

8. AGE: Years	Months	Days	If less than one day
71	11	23	hrs. min.

9. Birthplace: Ohio. (Town, county, and state)

10. Usual occupation: Retired -

11. Industry or business: U. S. Government

FATHER — 12. Name: Alexander Hawthorne

FATHER — 13. Birthplace: Ohio

MOTHER — 14. Maiden name: Magdred McLaughlin

MOTHER — 15. Birthplace: Ohio.

16. Informant: Mrs Nelle P. Hawthorne

Address: 10211 Conn. ave Kensington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 22nd 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Rance Rance County, Md

19. Funeral director: Joseph F. Burch & Sons

Address: 3004 - 9th St. N.E. Wash. D.C.

19. Jan 20 1947 (Date rec'd by registrar) Josephine M. Schaffer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20 1947, at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945, to Jan 20 1947 and that I last saw h... alive on Jan 20 1947

Immediate cause of death	DURATION
Coronary Thrombosis	6 hours
Due to	
Due to	
Other conditions: Hypertension Heart disease	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Marion Sandoval M.D. (M. D. or other)

Address: Silver Spring, Md. Date signed: 1/20/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95b 00704

92b

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Dec. 24, 1946

Hospital, institution, or street address where death occurred:
Suburban Hosp. - 8600 Old Georgetown Rd.

How long in hospital or institution? Since Dec. 24, '46 Bethesda Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Boyds
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr Edward Hege

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, Married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Rose Elva Hege

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 10, 1906

8. AGE:	Years	Months	Days	If less than one day
	40	7	26	....hrs. ....min.

9. Birthplace Marysville Pennsylvania
(Town, county, and state)

10. Usual occupation Laborer (Unem

11. Industry or business

FATHER 12. Name Hanson Hege

13. Birthplace ? Pennsylvania

MOTHER 14. Maiden name Laura Kay

15. Birthplace ? Pennsylvania

16. Informant Rose E Hege

Address unknown

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 9 1947 (month) (day) (year)

Cemetery or crematory Carlisle Pa

Location Pa

18. Funeral director Roy W Barber

Address Taylorsville Md

19. 1/6 1946 Wm E Jobes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1947, at 9 32 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 24 1946, to JAN 6 1947

and that I last saw h. IM alive on JAN 6 1947

Immediate cause of death	DURATION
MYOCARDIAL FAILURE	6 Mo.
Due to Rheumatic Heart Disease	23 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results Contracting; mitral stenosis; coronary heart failure; ischemia; mural thrombosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dewitt E Lefevre MD. M. D. or other

Address SUBURBAN HOSPITAL Bethesda, 14, Md Date signed Jan 5 47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163H

00705

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 1929
Hospital, institution, or street address where death occurred:
4400 Elm Street.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4400 Elm St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Alice D. Hollis

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm. Stanely Hollis deceased
6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): Dec. 22, 1880

8. AGE: Years	Months	Days	If less than one day
67	1	21	....hrs. ....min.

9. Birthplace: Scotland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James Davidson
13. Birthplace: Scotland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Scotland

16. Informant: James George Hollis
Address: 4400 Elm St. Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/47 (month) (day) (year)
Cemetery or crematory: Arlington Natl. Cemetery
Location: Arlington, Virginia

18. Funeral director: W Reuben Tewphrey
Address: Bethesda, Maryland

19. 1/13 1947 (Date rec'd by registrar) Mr E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13 19 47, at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 Med. Exam Case 19..., to ...19..., and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death: Asphyxia due to illuminating gas (suicide)	Few minutes
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 1-13-47
Where did injury occur? Chevy Chase (City or town) Mont. (County) Md (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broccard M.D. Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md Date signed 1-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

147c

06706

CERTIFICATE OF DEATH

Reg. Dist. No. 223

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years.

Hospital, institution, or street address where death occurred: 9311 Walden Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 9311 Walden Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Agnes Mead Hooker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Allen E. Hooker.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 7- 1917

8. AGE: Years: 29 | Months: 8 | Days: 17 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Lucknow India
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Quiet Home

FATHER
12. Name: Walter S. Mead
13. Birthplace: Battle Creek, Michigan.

MOTHER
14. Maiden name: Geneive Glenna
15. Birthplace: Fawrie Iowa

16. Informant: Mrs. Allen Hooker
Address: 9311 Walden Road - Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan - 27- 1947 (month) (day) (year)

Cemetery or crematory: Georgia Washington Memorial

Location: Lyttonsville, Reggie Road - R.F.D.

18. Funeral director: Arthur L. Talbert.

Address: 254 Carroll St. N.W. Takoma Park, D.C.

19. Jan. 25 1947 (Date rec'd by registrar) Melvin Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1947 at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 3 1946 to Jan. 24 1947

and that I last saw h.e.s. alive on January 23 1947

Immediate cause of death	DURATION
Prob. Coronary Embolism	30 min.
Due to: Pelvic Thrombosis 8th Post-natal day	3 -
Due to:	
Other conditions: 8th Post-Natal day (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Silver Spring, Md. Date signed 1/24/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00707

CERTIFICATE OF DEATH

93d ★

Reg. Dist. No. 716

1. PLACE OF DEATH:
County Montg.
City or town Cabin John
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Cabin John
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7 Locks, Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARY JACKSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Colored	Widow

6.(b) Name of husband or wife Fred Jackson
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 69 | Months | Days | If less than one day hrs. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business

FATHER
12. Name William Neal
13. Birthplace Unknown

MOTHER
14. Maiden name Frances Harper
15. Birthplace Virginia

16. Informant Mrs. Josephine Owens
Address 517 Florida Ave. N. W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1/10/47 (month) (day) (year)
Cemetery or crematory Nash. D.C.
Location
18. Funeral director W. Ernest Jarvis Co.
Address 1432 You St. N. W.

19. 1/11 19 47 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1947 at 11:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1947 to June 10 1947 and that I last saw h alive on January 8 1947

Immediate cause of death	DURATION
Influenza	
Due to Cardio-Vascular Disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. A. A. Dunn M. D. or other
Address Bethesda Md. Date signed 1-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

00708

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
6615 Strathmore St.
How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6615 Strathmore St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: LILLIAN MC KINNON JELLIFFE

3.(b) Social Security Number: 579-09-6486

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Maltby Jelliffe
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): June 18, 1895

8. AGE: Years	Months	Days	If less than one day
51	7	6	...hrs. ...min.

9. Birthplace: Cambridge, Mass. (Town, county, and state)
10. Usual occupation: Manager
11. Industry or business: Jelleff's Inc.

FATHER
12. Name: John W. McKinnon
13. Birthplace: Scotland

MOTHER
14. Maiden name: Lillian Robinson
15. Birthplace: Concord, Mass.

16. Informant: Mr. Maltby Jelliffe
Address: 6615 Strathmore St. Chevy Chase, Md.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 1/29/47 (month) (day) (year)
Cemetery or crematory: Three Bridges, New Jersey
Location: New Jersey

18. Funeral director: Wm Reuben Pumphrey
Address: 7557 Wis. Ave. Bethesda, Maryland

19. 1/27/47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 24, 1947, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1944, to Jan 24 1947
and that I last saw her alive on Jan 22 1947

Immediate cause of death	DURATION
Generalized Carcinomatosis	6 mos.
Due to: Carcinoma of Breast	3 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Hill Carter, M. D. or other
Address: 1835 Eye St NW Date signed: 1-24-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161a

00709

CERTIFICATE OF DEATH

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hrs 39 min.

Hospital, Institution, or street address where death occurred:
Washington San. + Hospital, Takoma Park, Md.

How long in hospital or institution? 6 hrs 39 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County D.C.

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5921 14th St N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Unnamed Baby Girl Johnson.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1947.

8. AGE: Years	Months	Days	If less than one day
			6 hrs. 39 min.

9. Birthplace Washington Sani. Hospital, Takoma Park, Md.
(Town, county, and state)

10. Usual occupation infant

11. Industry or business

FATHER
12. Name John Irwin Johnson
13. Birthplace Wash. D.C.

MOTHER
14. Maiden name Catherine Marie Simon.
15. Birthplace Patterson, N.J.

16. Informant Mother's chart Washington Sani. Hospital
Address Takoma Park, Md.

17. Burial Date thereof Jan 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt Olivet Cemetery
Location Washington D.C.

18. Funeral director Francis Collins
Address 3821-14th St. N.W. Wash. D.C.

19. Jan 27 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1947, at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-26 1947, to 1-26 1947 and that I last saw her alive on 1-26 1947

Immediate cause of death	DURATION
Asphyxia	7 hrs.
Due to Congenital atelectasis	7 hrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel M. Bryant M.D.
M. D. or other

Address Wash. D.C. Date signed 1/27/47

VS A15 9.45 15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00710 — Reg. Dist. No. 2231

1. PLACE OF DEATH:
County: Montgomery County
City or town: ~~Takoma Park~~ Washington Sanitarium
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Washington Sanitarium + Hosp
How long in hospital or institution? 36 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: ~~Takoma Park~~ Washington Sanitarium
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington Sanitarium
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. Robert Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	widow.

6.(b) Name of husband or wife: deceased
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 15, 1864

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
82	5	1		

9. Birthplace: Fredrick Co. Va.
(Town, county, and state)
10. Usual occupation: Blacksmith
11. Industry or business:

FATHER
12. Name: —
13. Birthplace: —

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: Hospital Chart
Address: Washington Sanitarium

17. Burial, cremation, or removal. Which?: Removal — Date thereof: Jan. 19, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Hebron
Location: Winchester Virginia

18. Funeral director: S.H. Ames Co.
Address: 2901-14 St. NW

19. (Date rec'd by registrar) Jan 17 1947 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 16th 1947, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1943 to Jan. 16 1947 and that I last saw him alive on Jan. 16 1947

Immediate cause of death	DURATION
Carcinoma prostate	3 yrs.
Due to: c Metastases liver, + retroperitoneal glands	"
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: obturator blocks —
Date of op.:
Autopsy results: as above —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John F. Braunsberger M.D. (M. D. or other)
Address: Takoma Park Date signed: 1-16-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-223d — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1952 182 * 00711

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outsido city or town limits, write RURAL and give nearest town)
How long in above place of death? Several hours
Hospital, institution, or street address where death occurred:
9208 Kensington Pkwy.,
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residonco of mother)
State Maryland Couoty Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4714 Chevy Chase Blvd.,
(If rural, give LOCATION)
2.(a) If veteran, nama war No

3.(a) FULL NAME: INFANT RUSSELL BRUCE JOHNSON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of huaband or wife: None
----- 6.(c) If alive, give age ---- years

7. Birth date of deceased (mo., dey, yr.): August 30, 1946

8. AGE: Yeara	Months	Days	If less than ooe day
0	4	5	- hrs. - min.

9. Birthplace: Bethesda, Maryland Montg. Co.
(Town, eounty, and state)

10. Usual occupation: None
11. Industry or businaaa: None

FATHER
12. Name: Russell L. Johnson
13. Birthplace: Youngstown, Ohio

MOTHER
14. Maiden name: Rosalie Nebel
15. Birthplace: Washington, D. C.

16. Informant: Rubbell L. Johnson (father)
Address: 4714 Ch. Ch. Blvd., Chevy Chase, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 1/7/47 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Maryland

18. Funeral director Wm Reuben Humphreys
Address Bethesda, Maryland

19. 1/7 (Date recd by registrar) 1947 Wm E. Kelley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5, 1947, at 6:30 P M

21. I CERTIFY that death occurred on the date above atated; that I attended deceaaed from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Dep. Med. Exam. Case	
Asphyxia Accidental	sudden death
Due to	
Due to	
Other conditiona	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of Jan. 5, 1947
Where did injury occur? Chevy Chase (City or town) Montgomery (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Maans of injury ..... Injured at work?

23. SIGNATURE Frank J. Burnhart M.D. M. D. or other
Address Gaithersburg, Md. Date signed 1/6/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d [illegible] 00712

Reg. Diat. No. 716

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long le above place ol death? 12 Years

Hospital, Institution, or street address where death occurred: 4612 Chevy Chase, Maryland

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of motber)

State: Maryland County: Montgomery

City or town: Chevy Chase, Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. 4612 Chevy Chase, (If rurai, give LOCATION)

2.(a) 11 veteran, name war: No

3. (a) FULL NAME: MRS. MATILDA T. KERNAN

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

8.(b) Name of husband or wife: Eugene C. Kernan

6.(c) 11 alive, give age ..... years

7. Birth date ol deceased (mo., day, yr.): Nov. 1, 1869

8. AGE: Years	Months	Days	11 less than one day
77	2	10	..... hrs. ..... min.

9. Birthplace: Reading, Pa. (Town, county, nnd state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John B. Taylor

13. Birthplace: England

MOTHER — 14. Malden name: Anna Waddell

15. Birthplace: Scotland

16. Informant: Aileen K. Cox, Daughter

Address: 5814 Sherry Place, N. W.

17. Shipment (Burial, cremation, or removal. Which?) Date thereol Jan. 14, 1947 (month) (day) (year)

Cemetery or crematory: Chas. Evans Cemetery,

Location: Reading, Pa.

18. Funeral director: Wm Reuben Humphreys

Address: Bethesda, Maryland

19. 1/13 (Date rec'd by registrar) 1947 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 11, 1947, at 2.45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12, 1946, to Jan. 12, 1947

and that I last saw h... alive on Jan 10, 1947

Immediate cause ol death: Arteriosclerotic heart disease — DURATION: 2 years.

Due to:

Due to:

Other conditions: Non-functioning gall bladder; Spastic transverse colon. (Include pregnaney within 3 months of death)

Major findings ol operations: none — Date of op.:

Autopsy results: none.

PHYSICIAN: Please underline the canse to which death should be charged statistically.

22. VIOLENCE: 11 death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date ol

Where did injury occur? (City or town) (County) (State)

Injured st home, 1arm, Industry, public place (where?)

Means of injury: Injured st work?

23. SIGNATURE: C. P Ryland, M. D. or other

Address: 4901 Mass Ave N.W. Date signed: 1-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

00713

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 917 18ths Street, NW
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: KINNEY, Robert (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 25, 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
~~57~~ 56	10	17		

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: Marlboro Apartment House

FATHER
12. Name: Charles Kinney
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Arnett
15. Birthplace: Virginia

16. Informant: Miss Mary Kinney

Address: 917 18th St. NW, Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-12-47 (month) (day) (year)

Cemetery or crematory: Louisa Cemetery

Location: Louisa, Md.

18. Funeral director: W. Ernest Parris Co.

Address: 1432-[illegible] St. N.W. Mary Charlotte Smith

19. 1-10 1947 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 January 1947 at 4:28 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 Dec. 1946 to 10 Jan 1947 and that I last saw him alive on 10 Jan 1947

Immediate cause of death	DURATION
Uremia	1 mo
Due to: Chronic glomerular nephritis	
Due to:	
Other conditions: hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: O. W. THOMPSON, Lt.Cdr.(MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-10-47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

1/18/47

2-25

2-21.6a 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

00714

Reg. Dist. No. 4-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

1612 North Springwood Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1612 N. Springwood Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: MARTHA W. KIRBY

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	seperated

6.(b) Name of husband or wife: Edward W. Kirby

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 17th. 1887

8. AGE: Years	Months	Days	If less than one day
59	7	12	..... hrs. ..... min.

9. Birthplace: Sunbury, Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: John H. Blain

FATHER — 13. Birthplace: Pa. (Perry Co.)

MOTHER — 14. Maiden name: Kate Smith

MOTHER — 15. Birthplace: Rockville, Pa.

16. Informant: Mr. John B. Kirby (son)

Address: 1612 N. Springwood Dr.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 2-1-1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland, Pr. Geo's Co., Md.

18. Funeral director: Howard E. Humphrey

Address: Silver Spring, Md.

19. Jan 31 1947 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 29 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Jan 29 1947 and that I last saw h.. alive on Jan 27 1947

Immediate cause of death	DURATION
Carcinoma of breast	8 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas H. Karnbryer M.D. M. D. or other

Address: 4201 New Hamp. ave Washington DC Date signed: 1/30/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1246

00715

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4801 Connecticut Avenue, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: KNIGHTON, Mary Ozora Spicknall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Col. Joseph W. Knighton
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 14 July 1898

8. AGE: Years	Months	Days	If less than one day
48	6	22	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: John Spicknall
13. Birthplace: Ky. (dec)

MOTHER
14. Maiden name: Emma Turnwoll
15. Birthplace: Md. (dec)

16. Informant: husband: Col. Joseph W. Knighton
Address: 4801 Conn., Avenue, N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-8-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

19. Funeral director: S. H. HINES
Address: 2901 14th St., N.W., Wash., D.C.

1-6 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 January 1947, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 December 1946 to 6 January 1947 and that I last saw him alive on 6 January 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 hrs
Due to:	
Due to:	
Other conditions: Acute pyelonephritis	10 days

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: T. S. Barnes
T. S. BARNES, Lt. Cdr. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 1-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1/11/47

2-25

2-2160 - 2-10

00716

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 18days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mayrland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 700 Thayer Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN A. KRAMER

3.(b) Social Security Number: 204-12-8061

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Doris M.a
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 18th. 1925

8. AGE: Years	Months	Days	If less than one day
21	3	22	..... hrs. ..... min.

9. Birthplace: Lehighton, Penna.
(Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business

FATHER
12. Name: Andrew Kramer
13. Birthplace: Poland

MOTHER
14. Maiden name: Esther Einhurst
15. Birthplace: Poland

16. Informant: Mrs. Doris M. Kramer (wife)
Address: 700 Thayer Ave. Silver Spring, Md.

17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-1947 (month) (day) (year)
Cemetery or crematory: Fairview
Location: Allentown, Lehigh Co. Pa.

18. Funeral director: Wane E Humphrey
Address: SilverSpring, Md.

19. 1/15 1947 (Date rec'd by registrar) Wm E Jobe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 Jan 1947 at 9:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Nov 1946 to 10 Jan 1947 and that I last saw h... alive on 10 Jan 1947

Immediate cause of death: Chronic Glomerulo nephritis — DURATION: 14 yrs
Due to: Scarlet fever, in 1932. — Chronic
Due to:
Other conditions: Hypertension
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

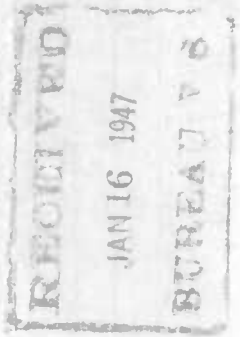
23. SIGNATURE: William D. And M.D.
M. D. or other
Address: Silver Spring Md. Date signed: 11 Jan 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Change in cause of d. made after answer to IA - Peoria
Dr. Aud. 3/17/47. A.S.



1-35

Evidence for the change of age is shown on G 108 2/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

00717

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3:50 P.M. Jan. 16, 1947
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6703 46th St.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: MRS. EUDORA MAUDE LAMPTON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: William M. Lampton
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Jan. 22, 1947

8. AGE: Years	Months	Days	If less than one day
67	11	24	...hrs. ...min.

9. Birthplace: Ashlon County, Ohio (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: none

FATHER
12. Name: Napoleon Gates
13. Birthplace: Mansfield, Ohio

MOTHER
14. Maiden name: Martha Gates
15. Birthplace: Richland Co., Ohio

16. Informant: Mr. William M. Lampton
Address: 6703 - 46th St. Chevy Chase, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Jan. 18, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.

18. Funeral director: Wm. Reuben Pumphrey
Address: 7557 Wis. Ave., Bethesda, Md.

19. 1/18 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/16 1947, at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/17 1946, to 1/16 1947 and that I last saw h...e alive on 1/16 1947

Immediate cause of death	DURATION
Cerebrovascular Hemorrhage	
Due to: hypertensive Cardiovascular Disease	
Due to:	
Other conditions: Congestive Heart Failure	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irving L. Marks, M.D. M. D. or other
Address: 4601 Leland St. Date signed: 1/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

00718

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 13 Hilltop Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: MONTGOMERY
City or town: SILVER SPRING, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 13 HILLTOP RD.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MRS. SUSANNA LERCH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	W.

6.(b) Name of husband or wife: ROBERT L. LERCH.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): FEB. 5. 1865.

8. AGE: Years	Months	Days	If less than one day
80	11	24	..... hrs. ..... min.

9. Birthplace: PHILA. PENN. (Town, county, and state)
10. Usual occupation: RETIRED.
11. Industry or business
FATHER 12. Name: ROBERT SIMMONS
13. Birthplace: PENN.
MOTHER 14. Maiden name: MARY P. ROE.
15. Birthplace: PENN.
16. Informant: MRS. WM. E. BRICE.
Address: 5. HILLTOP RD. Sil. Sp. MD.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 1-29-47 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cem.
Location: Hyattsville, Md.
18. Funeral director: Jos. Saunders Sons
Address: 1756 Penn Ave. N.W.
19. Jan 30 1947 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 29, 1947, at 7:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1947 to Jan. 29, 1947 and that I last saw h... alive on Jan. 28, 1947

Immediate cause of death	DURATION
Heart failure	
Due to: Chronic Myocarditis	Sev. yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Raymond Metzger M.D.
M. D. or other
Address: 6940 Piney Br. Rd. Md. Washington, D.C. Date signed Jan. 29, 1947

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00719

108

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, (Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. Beltsville - Box 102

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Bertha Williams Lewis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Howard Perry Lewis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 22, 1882

8. AGE: Years	Months	Days	If less than one day
64	3	17	..... hrs. ..... min.

9. Birthplace Richmond Co. Virginia

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Griffin Williams

13. Birthplace Westmoreland Co. Va.

MOTHER 14. Maiden name Elizabeth C. Williams (Duff)

15. Birthplace —

16. Informant Hospital records

Address

17. Removal Date thereof Jan. 9, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory To Washington D.C.

Location

18. Funeral director James T. Ryan Inc.

Address 317 Pa. Ave. S.E. Washington D.C.

19. 1-9- 19 47 Bertrude B. Lawler

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1947, at 7 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to Jan. 9 1947

and that I last saw her alive on January 9 1947

Immediate cause of death	DURATION
Acute Myocarditis	1 day
Due to Lobar Pneumonia	10 days
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operation None.

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md. Date signed 1/9/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00720

97

CERTIFICATE OF DEATH

Reg. Dist. No. 2186

1. PLACE OF DEATH:

County Montgomery

City or town Rural Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Year

Hospital, institution, or street address where death occurred:
Mrs Gaithr Rest Home

How long in hospital or institution? 1 Year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lillie W Linthicum

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife Charles J Linthicum

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 26 - 1868

8. AGE: Years	Months	Days	If less than one day
78	4	27	hrs. min.

9. Birthplace Montgomery Co Md
(Town, county, and state)

10. Usual occupation Iron

11. Industry or business —

MOTHER
12. Name Llewellyn Jones
13. Birthplace Montgomery Co Md

FATHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Darsy J Linthicum
Address Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 23 1947 (month) (day) (year)

Cemetery or crematory Baptist

Location Cedar Grove Md

18. Funeral director Roy W. Barber

Address Poolesville Md

19. Jan 22 1947 Alveda G Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January - 21 - 1947, at 2 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from — 1940 to Jan - 21 - 1947 and that I last saw h e alive on Jan - 26 - 1947

Immediate cause of death	DURATION
Senile Dementia	2 yrs
Due to Arteriosclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Miller M.D.
M. D. or other

Address Gaithersburg Md Date signed 1/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

516 00721

Reg. Diat. No. 2110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Clopitsville R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Clopitsville West Rural R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war 6

3.(a) FULL NAME George A Long

3.(b) Social Security Number 6

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife Rosa Long
6.(c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) Sept 6 - 1880

8. AGE: Years	Months	Days	If less than one day
66	3	27	hrs. min.

9. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation Blacksmith
11. Industry or business
FATHER 12. Name Milton Long
13. Birthplace Maryland
MOTHER 14. Maiden name Emma Pinnette
15. Birthplace Maryland
16. Informant Rena L. Brown
Address Clopitsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4 1947 (month) (day) (year)
Cemetery or crematory Brick Bethel
Location Mt Winsor Md
18. Funeral director Roy W Barber
Address Poolesville Md
19. Jan 4 1947 (Date rec'd by registrar) Della W. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1947 at 2:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1941 to January 7 1947 and that I last saw h.. alive on December 15 1946
Immediate cause of death Carcinoma of prostate with generalized metastases — DURATION 5 years.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James F. Kerr M.D.
M. D. or other
Address Damascus, Md. Date signed 1-8-47.

Evidence for the addition of items 17 shown on G 108 1/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

24a

00722

Reg. Dist. No. 2237

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days.

Hospital, institution, or street address where death occurred: Washington Sanitarium & Hospital

How long in hospital or institution? 15 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5411 Georgia Ave. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Rebecca Malawista

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Cauc.	married

6.(b) Name of husband or wife: Jacob Malawista

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 18 1896.

8. AGE: Years	Months	Days	If less than one day
51	3	26	hrs. min.

9. Birthplace: Odessa Russia (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER — 12. Name: Joseph Botkin

13. Birthplace: Russia

MOTHER — 14. Maiden name: Sonya Krapps

15. Birthplace: Russia

16. Informant: Records

Address: Washington San. & Hosp.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 14 1947 (month) (day) (year)

Cemetery or crematory: Wash. D.C.

Location: National Capital Hebrew Cemetery

18. Funeral director: Goldberg Funeral Home

Address: H-217-9 St. N.W.

19. Jan. 13 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1947 at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to Jan. 13 1947

and that I last saw her alive on Jan. 13 1947

Immediate cause of death: Staph. aureus septicemia — DURATION: 2 wks.

Due to:

Due to:

Other conditions: Endocarditis, Staph. aureus; Infarct, Spleen, Kidneys

(Include pregnancy within 3 months of death)

Major findings of operations: Gastroenterostomy 1892

Date of op. 10 yrs. ago

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. H. McGill M.D. M. D. or other

Address: Silver Spring, Md. Date signed: 1/13/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

00723

CERTIFICATE OF DEATH

Reg. Dist. No. 1236

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 hours.
Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hosp.
How long in hospital or institution? 19 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 709 Kennebec Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John milton Marple.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	white.	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 23 1922.

8. AGE: Years: 24 | Months: 1 | Days: 9 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Morgantown W. Va.
(Town, county, and state)

10. Usual occupation: Cab driver

11. Industry or business: Bell cab co.

FATHER
12. Name: Horace Hill Marple.
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Margaret E. Germon
15. Birthplace: Kansas city Kans.

16. Informant: Records - Washington San. & Hosp.
Address: Takoma Park Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 3 - 1947 (month) (day) (year)
Cemetery or crematory: George Mt. Moriah
Location: Rupp Road - Hyattsville Md.

18. Funeral director: J. Delmar Walters
Address: 7254 Carroll Ave. Takoma Park

19. Jan 2 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1 1947, at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 29 Med. Exam 1947, to ..... 19....., and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Rupture of ant. renal artery (Traumatic)	20 hrs.
Due to: History of injury — negative. Did not	
Due to: marked ad fall. Autop.	
Other conditions: Hypoplasia aorta & renal arteries	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? History of ice skating - no history of injury (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bouchard M.D.
Dep. Med. Examr. M. D. or other
Address: Gaithersburg md Date signed 1-1-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00724

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95c

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Suburban Hospital Bethesda MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Ten days

Hospital, Institution, or street address where death occurred: Suburban Hospital Bethesda MD

How long in hospital or institution? Ten days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Ceader Grove P.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Herbert Green Miles

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sarah J. Miles

Jan-1- 6.(c) If alive, give age 0 years

7. Birth date of deceased (mo., day, yr.): July 5. 1858

8. AGE: Years	Months	Days	If less than one day
88	6	11	...hrs. ...min.

9. Birthplace: Cedar Grove MD
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business: State Road

FATHER 12. Name: Green Miles

FATHER 13. Birthplace: Cedar Grove MD

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Cedar Grove MD

16. Informant: Harry Miles

Address: Rockville MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 19 1947 (month) (day) (year)

Cemetery or crematory: Salem

Location: Ceader Grove MD.

18. Funeral director: Roy W. Barber

Address: Laytonsville MD

19. 1/16 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 Jan 1947, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945 to 16 Jan 1947 and that I last saw h... alive on 15 Jan 1947

Immediate cause of death	DURATION
Acute Cardiac Decompensation	1 wk
Due to: Hypertension	20 yrs
Due to: Arteriosclerosis	30 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: W E Humphreys M.D. M. D. or Other

Address: Rockville Md Date signed: 16 Jan 47

8012

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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00725

61

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: BETHESDA (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital Bethesda Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 706 Vermont Street
(If rural, give LOCATION)

2.(a) If veteran, name war: Sp.Am.War

3.(a) FULL NAME: Francis Xavier MURPHY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1876

8. AGE:	Years	Months	Days	If less than one day
	70	3	15	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Retired Postal Clerk

11. Industry or business:

FATHER
12. Name: Francis Murphy dec.
13. Birthplace: N.Y.

MOTHER
14. Maiden name: Mary Quinn Dec.
15. Birthplace: Va.

16. Informant: Sister: Miss Mary J. Murphy
Address: 706 Vermont St. Arlington, Va.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 1-28-47 (month) (day) (year)

Cemetery or crematory: ARLINGTON NATIONAL CEMETERY

Location: ARLINGTON, VIRGINIA

18. Funeral director: W. W. CHAMBERS E.J.

Address: 1400 CHAPIN ST. NW. WASH. D.C.

19. 1-26- 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 January 19 47 at 2:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Dec. 1946, to 25 Jan 1947 and that I last saw h... alive on 25 January 1947

Immediate cause of death	DURATION
a Bronchopneumonia	10 days
Due to: Malnutrition	
Due to: Diabetes mellitus	
Other conditions: Generalized arteriosclerosis + hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Some c cardiac hypertrophy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C.W. Thompson C.W. THOMPSON LT CDR MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1/30/47

2-25

-2- 2160- 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00726

CERTIFICATE OF DEATH

Reg. Dist. No. 7-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:

708 Sligo Ave.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D.C. County DC.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 422 Butternut St. N.W. apt 23.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME RACHEL MARY PARKER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 30, 1872

8. AGE: Years	Months	Days	If less than one day
74	4	15	..... hrs. ..... min.

9. Birthplace East Lebanon, North Carolina

(Town, county, and state)

10. Usual occupation Assisted at Home

11. Industry or business

FATHER

12. Name Mr. John S. Parker

13. Birthplace Chester, New Hampshire

MOTHER

14. Maiden name Caroline Wood

15. Birthplace East Lebanon, ~~North Carolina~~ MAINE.

16. Informant Institution Records

Address 708 Sligo Ave. Sil Sp. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 18, 1947. (month) (day) (year)

Cemetery or crematory

Location East Lebanon, Maine.

16. Funeral director Wilbur Walters

Address 234 Carroll St. N.W., Takoma Park, D.C.

19. Jan 16 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1947, at 9 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1 1947, to 1/15 1947

and that I last saw h. alive on 1/15 1947

Immediate cause of death	DURATION
(a) Acute Myocarditis	
Due to (b) Decompensation	7 days.
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard T. Morse M.D.

M. D. or other

Address 28 Carroll Ave Takoma Park Md. Date signed 1/15/47

1-35

Evidence for additions made is shown on G 109 3/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00727

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 2230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Pk Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred: George Rest Home 100 Baltimore

How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 417 McGrath Pl. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ROSA Patti

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M.

6.(b) Name of husband or wife: Salvatore Patti

7. Birth date of deceased (mo., day, yr.): July 7, 1888 6.(c) If alive, give age: 62 years

Oct. 16, 1888

8. AGE: Years: 58 Months: Days: If less than one day: hrs. min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Salvatore Catè

13. Birthplace: Italy

MOTHER 14. Maiden name: Josephine Angeri

15. Birthplace: Italy

16. Informant: Rosina J. Mezzanucci

Address: 26 Westmoreland Ave

17. Removal (Burial) (Burial, cremation, or removal. Which?) Date thereof 1/31/47 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: 2121 Lincoln Rd. N. E. Wash. D. C.

18. Funeral director: The S. H. Hines Co.

Address: 2901 14th St. N.W.

19. Jan 28 1947 (Date rec'd by registrar) Wm Rodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28 1947 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 January 1947 to 28 January 1947

and that I last saw her alive on 28 January 1947

	OURATION
Immediate cause of death: Cerebral Hemorrhage	3 Days.
Due to: Hypertensive Heart disease	Several years.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: G B Cullen M.D. M. D. or other

Address: Takoma Park, Md. Date signed: 28 Jan 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

30g - 00728 Reg. Dist. No. 216 (

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1/24/47

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos 30 days
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 3 mos. 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 725 7th St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st WW ✓

3.(a) FULL NAME
PETERS, James Clifton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 26, 1896

8. AGE: Years	Months	Days	If less than one day
50	5	22	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business

FATHER
12. Name: Henry Peters
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rachel Stewart
15. Birthplace: Maryland

16. Informant: Jennie Peters (sister)
Address: 725 7th Street, NW, Washington, D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 1-24-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia W. Barnes
18. Funeral director: Ernest W. Jarvis W. Ernest Jarvis
Address: 1432 U St. NW, Washington, D. C.

19. 1-18-47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 January 19 47 at 11:33 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Sept. 19 46, to 17 Jan 19 47
and that I last saw h alive on 19

Immediate cause of death	DURATION
Congestive failure	2 years
Due to aortic insufficiency	
Due to dilatation incident to hypertension	
Other conditions generalized arteriosclerosis, syphilis.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. W. Thompson C. W. Thompson, LCDR, MC, USN
Address: USNH Bethesda, Md. M. D., or other Date signed 1-18-47

2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-c)

00729

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:
104 E. Melrose St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Chevy Chase, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 E. Melrose St.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: ELIZABETH P. PRINDLE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Louis M. Prindle

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): May 29, 1863

8. AGE: Years	Months	Days	If less than one day
83	7	15	hrs. min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: John C. Pushee

13. Birthplace: New York

MOTHER — 14. Maiden name: Eliza Hunt

15. Birthplace: New York

16. Informant: Mr. Louis M. Prindle

Address: 104 E. Melrose St. Chevy Chase, Md

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 1/15/47 (month) (day) (year)

Cemetery or crematory: Pine Hill Cemetery in N. H.

Location: New Hampshire, Mass.

19. Funeral director: W. Reuben Swan Funeral Service

Address: Bethesda, Maryland

19. 1/15 1947 (Date rec'd by registrar) Wm E Johns (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 14 1947 at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to Jan. 14 1947 and that I last saw her alive on Jan. 14 1947

Immediate cause of death	DURATION
Congestion of lungs due to Cardiac failure	2 week
Due to: Patient was greatly over weight, causing poor circulation. There was no evidence of renal	
Due to: disease or heart disease. Senility	
Other conditions: Senility without senile dementia.	6 months

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? no (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: W. W. Prentiss M.D.

Address: 5425 Conn. Ave. Washington, 15, D.C. M. D. or other Date signed: Jan. 14/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a ★ 00730

CERTIFICATE OF DEATH

Reg. Dist. No. 2170

1. PLACE OF DEATH:
County Montgomery Co. 2nd Hospital
City or town Olney - Md -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? from Jan 15 To Jan 23rd 1947
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery -
City or town Bait Hess Long Clarksburg -
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William S. Purdum

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Katie Murphy Purdum
6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) May 19, 1871 -

8. AGE: Years	Months	Days	If less than one day
75 years -			hrs. min.

9. Birthplace Near Clarksburg - Md
(Town, county, and state)
10. Usual occupation Retired mail courier
11. Industry or business

FATHER
12. Name Charles Thomas Purdum
13. Birthplace Maryland

MOTHER
14. Maiden name Harriet Blunt
15. Birthplace Maryland -

16. Informant Mrs Sprig ward -
Address Gaithersburg Md -

17. Burial Date thereof 1/26/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Babbs Church Cemetery
Location Cedar Grove Md -
19. Funeral director Ernest C Gaither
Address Gaithersburg route

19. 1-25- 1947 Gertrude B Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1947, at 4:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/15/47 1947 to 1/23/ 1947.
and that I last saw him alive on Jan. 22, 1947.

Immediate cause of death	DURATION
Uremia -	3 days
Due to Chronic Interstitial nephritis	2 yrs.
Due to	
Other conditions Hypertrophied prostate with retention	10 days

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D.
Address Sandy Spring, Md Date signed 1/23/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

00731

2231

Reg. Diat. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:

County Montg.

City or town TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

45 POPLAR AVE.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County

City or town TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

Street No. 45 POPLAR AVE.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME FLORENCE C. REILY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Phillip

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862 (?)

8. AGE: Years	Months	Days	If less than one day
84 (?)			hrs. min.

9. Birthplace Newport R.I.

(Town, county, and state)

10. Usual occupation At home

11. Industry or business

FATHER 12. Name Un Known

13. Birthplace "

MOTHER 14. Maiden name

15. Birthplace "

16. Informant H.G. King

Address Investment Bldg

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 6-1947 (month) (day) (year)

Cemetery or crematory Island Cemetery

Location Newport, R.I.

18. Funeral director Joseph Gawler's Sons

Address 1756 Penn. Ave.

19. Jan 2 1947 (Date rec'd by registrar) J. A. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2nd 1947, at 2 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3rd 1944, to Jan 2nd 1947 and that I last saw h[illegible] alive on Dec 31st 1946

Immediate cause of death	DURATION
Myocardiosclerosis Heart Decay	6 months
Due to Arteriosclerosis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wallace C. Simpson M.D. M. D. or other

Address 15-14-30th Date signed Jan 2nd 1947

1-25

2-2230 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00732

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 days

Hospital, institution, or street address where death occurred:
USNH Bethesda, Md.

How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 500 9th St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: RICHARDSON, James Frederick VAP

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Widowed d

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 13 Sept. 1887

8. AGE: Years	Months	Days	If less than one day
59	4	13	..... hrs. ..... min.

9. Birthplace: Illinois
(Town, county, and state)

10. Usual occupation: .....

11. Industry or business: .....

FATHER — 12. Name: Jessie Richardson

FATHER — 13. Birthplace: Illinois

MOTHER — 14. Maiden name: Margaret Van Norstrand

MOTHER — 15. Birthplace: Illinois

16. Informant: Son: James Walter Richardson

Address: 500 9th St. S.E. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-29-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Wm. J. Lee & Sons Corr

Address: 4th & Mass., Avenue, N.E., Wash., D.C.

19. 1-26 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 January 1947, at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 Dec. 1946, to 26 Jan 1947 and that I last saw him alive on 26 Jan 1947

Immediate cause of death	DURATION
Thrombosis, Coronary artery	
Due to: generalized arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

C. W. THOMPSON, Lt.Cdr.(MC) USNR

23. SIGNATURE ..... M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1/30/47

2-25

2-2160 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00733

55e

Reg. Dist. No. 2161

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 24 days

Hospital, institution, or street address where death occurred:
USNH, Bethesda, Md.

How long in hospital or institution? 3 mos. 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1420 Harvard Street, NW
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: RUSSELL, Reginald Rike

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Mabel Russell

7. Birth date of deceased (mo., day, yr.): ~~August 12, 1887~~ Aug 12, 1887

6.(c) If alive, give age: ..... years

8. AGE: Years	Months	Days	If less than one day
59	4	22	..... hrs. ..... min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: Civil Service (Interior Dept.

11. Industry or business:

FATHER
12. Name: Simmion Russell
13. Birthplace: unknown

MOTHER
14. Maiden name: Mabel Rike
15. Birthplace: unknown

16. Informant: Mrs. Mabel Russell wife

Address: 1420 Harvard St. NW, Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-7-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cem.

Location: Arlington, Virigvinia

18. Funeral director: Hines Funeral Director

Address: 2901 14th St., NW, Wash., D.C.

19. 1-3- 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 January 19 47 at 9:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 19 46, to 3 Jan 19 47

and that I last saw him alive on 3 Jan 19 47

	DURATION
Immediate cause of death: Lymphosarcoma	18 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Lymphosarcoma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. L. JONES, Jr. Comdr. (MC) USN (M. D. or other)

Address: USNH Bethesda, Md. Date signed: 1-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1/14/47

2-25

2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

926 00734

Reg. Dist. No. 314

1. PLACE OF DEATH

County Montgomery Co

City or town 9508 Baltimore Dr

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1 year 10 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9508 Baltimore Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MILDRED SAUNDERS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1861

8. AGE: Years	Months	Days	If less than one day
85			..... hrs. ..... min.

9. Birthplace Steubenville, Ohio

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John H. Saunders

13. Birthplace Maine

MOTHER 14. Maiden name Sarah Kelbe

15. Birthplace Steubenville, Ohio

16. Informant Wm. B. Saunders (brother)

Address 1432 Newton St NW Wash DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13, 1947 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Wash DC

18. Funeral director S. H. Davis Co

Address 2901 - 14th St NW Wash DC

19. Jan 10 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1947 at 4.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1940 to Jan. 10 1947

and that I last saw h.. L.. alive on JAN. 7 1947

Immediate cause of death Cardiac dilatation — DURATION 3 days

Due to

Due to

Other conditions Hypertention, mitral regurgitation & decompensation

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm A Thomson M.D. M. D. or other

Address 113 Carroll St NW Date signed Jan 10, 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00735

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49 days.

Hospital, institution, or street address where death occurred: Montgomery County General Hospital.

How long in hospital or institution? 49 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rural - Brighton

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rurol, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Charles Schneider

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	wh.	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1877

8. AGE: Years	Months	Days	If less than one day
69	11	3	...hrs. ...min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Meat cutter

11. Industry or business: Meat

FATHER 12. Name: John C. Schneider

13. Birthplace: Washington, DC.

MOTHER 14. Maiden name: Mary Margaret Gallagher

15. Birthplace: Virginia

16. Informant: Catherine Schneider Eckloff

Address: Brinklow, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-16-47 (month) (day) (year)

Cemetery or crematory: Prospect Hill Cem.

Location: Washington, D.C.

18. Funeral director: Joseph F. Birch's Sons

Address: 3034-M Street, N.W. - Wash. D.C.

19. 1-13- 1947 Gertrude B. Lawler

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1947, at 2:40 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 26 1946, to January 13 1947

and that I last saw h.i.m. alive on January 13, 1947

Immediate cause of death	DURATION
Uremia	3 months
Due to: Chronic Glomerulonephritis.	years.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Richard A. Yates M.D. (M. D. or other)

Address: Sandy Spring Md. Date signed 1/13/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00736

Reg. Dist. No. 217

PLEASE WRITE CLEARLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:
County Montgomery Co. Gen. Hospital
City or town Olney - Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Two days
Hospital, institution, or street address where death occurred
How long in hospital or institution? Jan 25th to Jan. 27th 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY
City or town ROCKVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 BEVERLY RD - MANOR CLUB ESTATES
(If rural, give LOCATION)
2.(a) If veteran, name war No -

3.(a) FULL NAME MR. EDWIN - SEASLEY -

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 20th - 1872

8. AGE: Years	Months	Days	If less than one day
74	6	7	..... hrs. ..... min.

9. Birthplace Cambridge - Massachusetts -
(Town, county, and state)
10. Usual occupation Office (Retired)
11. Industry or business

FATHER
12. Name Frederick Seasley
13. Birthplace GERMANY

MOTHER
14. Maiden name Attilla Fuller
15. Birthplace GERMANY

16. Informant MRS CHARLES E NICHOLS
Address 109 - BEVERLY RD - MANOR CLUB ESTATES.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 1 - 30 - 1947 (month) (day) (year)
Cemetery or crematory COLESVILLE METHODIST CHURCH
Location COLESVILLE - MD.

18. Funeral director Wane E Humphrey -
Address SILVER SPRING - MD.

19. 1 - 30 - 1947 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

permit issued by Silver Spring, Md. Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27/ 1947, at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 11 1946, to 1/27/ 1947
and that I last saw h... alive on 1/27/ 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	1 yr
Due to Pancreas	
Due to obstruction jaundice	3 wks
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. —
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ✓ Date of ✓
Where did injury occur? ✓ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ✓
Means of injury ✓ Injured at work? ✓

23. SIGNATURE [signature] M. D. or other
Address Sandy Spring Md. Date signed 1/27/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 00737

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: BETHESDA
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred: SUBURBAN HOSPITAL
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. of Col. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3922 Morrison St., Chevy Chase, D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MR. HARRY LODGE SELBY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: MRS. LILLIE SELBY
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Jan. 25, 1881

8. AGE:

Years	Months	Days	If less than one day
65	11	18	....hrs. ....min.

9. Birthplace: WASHINGTON, D.C.
(Town, county, and state)

10. Usual occupation: BANKER

11. Industry or business:

FATHER
12. Name: MR. WILLIAM S. SELBY
13. Birthplace: T.B., Maryland

MOTHER
14. Maiden name: MARY ELIZABETH HURDLE
15. Birthplace: WASHINGTON, D.C.

16. Informant: MRS. AMY ROCHE (daughter)
Address: 3922 Morrison St., Chevy Chase, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Washington, D. C.

18. Funeral director: Joseph F. Birch's Son
Address: 6034 Mass. Ave. N.W. Washington, D.C.

19. 1/12 1947 (Date rec'd by registrar) Wm. E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12, 1947, at 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to January 12 1947
and that I last saw h.im alive on January 11 1947

Immediate cause of death	DURATION
Myocardial infarction	5 days
Due to	
Due to	
Other conditions Pulmonary tuberculosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. G. Sanders, M.D. M. D. or other
Address: 3922 Morrison St. Chevy Chase D.C. Date signed: 1/12/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

30g ★ 00738

Reg. Dist. No. 2161

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred: US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr. Georges

City or town: Bladensburg,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4208 53rd Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME: SKEELE, Charles Walcutt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Barbara Skeele

6.(c) If wife, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 9 May 1880

8. AGE:

Years	Months	Days	If less than one day
66	8	22	..... hrs. ..... min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER — 12. Name: Charles Skeele dec.

13. Birthplace: Ohio

MOTHER — 14. Maiden name: Elizabeth Humble dec.

15. Birthplace: Ohio

16. Informant: wife: Mrs. Barbara Skeele

Address: 4208 53rd Avenue, Bladensburg, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2 - 3 - 1947 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: HINES FUNERAL DIRECTOR

Address: 2901 14th St. NW, Wash., D. C.

19. 2-1 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 January 1947 at 3:44 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 January 1947 to 31 Jan. 1947 and that I last saw him alive on 31 January 1947

Immediate cause of death	DURATION
Bronchopneumonia	1 wk
Due to: arteriosclerotic heart disease	
Due to: general arteriosclerosis	
Other conditions: syphilis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: some

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury, ... Injured at work?

23. SIGNATURE: W Thompson USNR

C. W. THOMPSON, Lt. Cdr. (MC) M. D. or other

Address: USNH Bethesda, Md. Date signed 2-1-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

3/7/47

2-25

2-R160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00739

51c

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, Institution, or street address where death occurred:
USNH Bethesda, Md.
How long in hospital or inatitution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 202 Vanburen St., N.W.
(If rural, give LOCATION)
2.(a) If veleran, name war:

3. (a) FULL NAME
SOLEM, Henry Martin VAP

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mrs. Ann L. SOLEM
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 29 1902

8. AGE: Years	Months	Days	If less than one day
44	1	13	hrs. min.

9. Birthplace: South Dakota
(Town, county, and atate)
10. Usual occupation: unknown
11. Industry or buainasa

FATHER
12. Name: Henry N. Solem
13. Birthplace: Norway

MOTHER
14. Maiden name: Mary Vogland
15. Birthplace: Norway

16. Informant: Wife: Mrs. Ann L. Solem
Address: 202 Vanburen, St. WW WASH. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-14-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Virginia

18. Funeral director: Joseph Gawler Sons H. Williams
Address: 1756 Penn. Avenue N.W. Wash. D.C.

19. 1-12 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 January 1947 at 1030AM

21. I CERTIFY that death occurred on the date above atated; that I attended daceaaed from Dec. 26 1946, to 12 January 1947
and that I last saw h...im...alive on 12 Jan 1947

Immediate cause of death	DURATION
Teratoma Testis, mylemas with metastases to liver & left testicle	6 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Teratoma Testis with liver metastasis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. N. GRANT CDR (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 1-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1/14/47

2-25

2-2160 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00740

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County MONTGOMERY

City or town BETHESDA.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Suburban

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD. County MONTGOMERY

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6927 Arlington Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME RICHARD G. SOPER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife RUTH GREGORY SOPER

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1878

8. AGE: Years 68 | Months | Days | If less than one day hrs. min.

9. Birthplace DETROIT, MICH.
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant Mrs Ruth G. Soper

Address 6927 Arlington Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-3-47 (month) (day) (year)

Cemetery or crematory Rock Creek

Location Washington, D.C.

18. Funeral director Jos Gawler Sons

Address 1756 Pennsylvania, Wash, D.C.

19. 1/31 19 47 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31/47 19 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12/16/46 19 to 1/31/47 19 and that I last saw h[illegible] alive on 1/30/47 19

Immediate cause of death	DURATION
Cerebral infarction	5 hrs.
Due to Cerebral thrombosis	5 hrs.
Due to Cerebral arteriosclerosis	
Other conditions Coronary heart disease	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bernard J. Walsh M. D. or other

Address 900 17th St. N.W. Wash. D.C. Date signed 1/31/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

00741

Reg. Dist. No. 7140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgom

City or town Rural Kensington md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural Kensington Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary E Stitzer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fmal	W	Widow

6(b) Name of husband or wife John S Stitzer

6(c) If alive, give age 6 years

7. Birth date of deceased (mo., day, yr.) March 15 - 1865

8. AGE: Years	Months	Days	If less than one day
81	10	9	hrs. min.

9. Birthplace Fenwick Va (Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER 12. Name Noah Lamb

13. Birthplace Va

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Mrs Emma Holsinger

Address Kensington md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 26 1947 (month) (day) (year)

Cemetery or crematory Linwood Va

Location Linwood Church Va

18. Funeral director Roy W Barber

Address Laytonsville md

19. Jan 25 1947 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1947, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-7 1946, to 1-24 1947 and that I last saw h alive on 1-24 1947

Immediate cause of death	Cardiac Failure	DURATION
Due to	Chronic Myocarditis	
Due to		
Other conditions	Hypertension	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. D. Lucas M. D. or other

Address 9601 Georgia Ave Date signed 1-25-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

00742

Reg. Diat. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Springs (If outside city or town limits, write RURAL and give nearest town)

Street No. 8019 Eastern Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John B Switzer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Mattie Rosalie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 3rd 1887

8. AGE: Years	Months	Days	If less than one day
59			..... hrs. ..... min.

9. Birthplace Charleston W. Virginia (Town, county, and state)

10. Usual occupation Dir Personel I.C.C.

11. Industry or business Government

FATHER 12. Name Chas J Switzer

13. Birthplace Gallipolis Ohio

MOTHER 14. Maiden name Eva Ella Dowd

15. Birthplace Rockville Ind

16. Informant Mattie Rosalie Switzer

Address 8019 Eastern Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 15, 1947 (mooth) (day) (year)

Cemetery or crematory Rock Creek

Location Wash DC

18. Funeral director The S.H. Hines Co.

Address 2901-14th St NW

19. Jan 15 1947 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1947 at 3406 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 27 1946 to Jan 12 1947

and that I last saw h[illegible] alive on Jan 11 1947

Immediate cause of death	DURATION
Coronary Occlusion	(day)
Due to Cerebral Arterial Sclerosis	
Due to	10 day
Due to	
Other conditions None	

(Incinde pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please nederline the canse to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (Conoty) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jos Downs MD M. D. or other

Address 4808 8th NW Date signed Jan 12 47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

00744

Reg. Diat. No. 2230

1. PLACE OF DEATH:

County 200 Holley Avenue Mont

City or town Takoma Park Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Mont-

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 Holley Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mark Thistle-Thwaite

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	M.

6.(b) Name of husband or wife Mable Thistlethwaite

7. Birth date of deceased (mo., day, yr.) March 17 1879 6.(c) If alive, give age ..... years

8. AGE: Years 67 Months Days If less than one day ..... hrs. ..... min.

8. Birthplace Richmond Indiana (Town, county, and state)

10. Usual occupation Newspaper Reporter

11. Industry or business

FATHER 12. Name John P. Thistlethwaite

FATHER 13. Birthplace Ind

MOTHER 14. Maiden name Mary Fleming

MOTHER 15. Birthplace Ind

16. Informant Mable Thistlethwaite

Address 200 Holly Ave.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Jan. 17, 1947 (month) (day) (year)

Cemetery or crematory Ft Lincoln

Location

18. Funeral director The S. P. Hines Co

Address 2901 14th St. NW

19. Jan 14 1947 (Date rec'd by registrar) J. William Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Jan. 1947, at 2:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Jan 1947 to 14 Jan 1947

and that I last saw h.. alive on 14 Jan 1947

	DURATION
Immediate cause of death: Coronary Occlusion & myocardial infarction.	72 hrs.
Due to: Arteriosclerotic Kidney disease	Five years.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations ← Date of op. ←

Autopsy results ←

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G B Queen M.D.

M. D. or other

Address Takoma Park Md Date signed 14 Jan 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

Evidence for the change of year of birth is shown on G 108 2/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00745

121

CERTIFICATE OF DEATH

Reg. Dist. No. 716

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lottie Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Robert Thomas

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): October 10, 1881 1878

8. AGE: Years	Months	Days	If less than one day
65			... hrs. ... min.

9. Birthplace: Poolesville, Montgomery, Maryland (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Archie Beander
13. Birthplace: Md.

MOTHER
14. Maiden name: Ellen Wims
15. Birthplace: Md

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 2, 1947 (month) (day) (year)

Cemetery or crematory: Church Cemetery

Location: Poolesville Md.

18. Funeral director: R. L. Snowden

Address: Rockville Md.

19. 2-1-47 (Date rec'd by registrar) 19 ... W. E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 30, 1947 19 ... at 11:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 1946, to 30 Jan 1947

and that I last saw her alive on 30 January 1947

	DURATION
Immediate cause of death: Ruptured Appendicitis	12 hrs
Generalized Peritonitis	12 hrs
Due to	
Due to	
Other conditions: Diabetes Mellitus	unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Ruptured Appendix, Generalized Peritonitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: DeWitt E. DeLawter, M.D. M. D. or other

Address: Suburban Hospital Bethesda, Md. Date signed: 31 Jan 47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(87e) ★ 00746

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N.C. County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5033 12th St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: THOMAS, William Mack Donald

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 26, 1886

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
60	7	0		

9. Birthplace: N.C.
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: friend: Mrs. Ruby Miller
Address: 5033 12th St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-28-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Newbern, North Carolina

18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 1-27 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 January 1947, at 10: P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-14 1947 to 1-26 1947 and that I last saw him alive on 26 January 1947

Immediate cause of death	DURATION
Pseudobulbar Palsy	2 years
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. W. Mulder D. W. MULDER, Lt.(jg) (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2/3/47

2-25

2-2160-2-10

00747

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47C

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 13 days
Hospital, institution, or street address where death occurred:
US NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? 1 month, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County:
City or town: Carnegie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 119 Noblestown
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st WW

3.(a) FULL NAME: THORNE, Albert (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 27 December 1890

8. AGE: Years: 56 | Months: 0 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business:

FATHER
12. Name: William Thorne
13. Birthplace: Whales (dec.)

MOTHER
14. Maiden name: Jane Lewellyen
15. Birthplace: England (dec)

16. Informant: bro: Mr. James Thorne
Address: 119 Noblestown, Carnegie, Pa.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-17-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., N. W., Wash., D.C.

19. 1-14 19 47 (Date rec'd by registrar)
Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 January 19 47, at 1:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-1 19 46, to 1-14 19 47
and that I last saw him alive on 14 January 19 47

	DURATION
Immediate cause of death: Bronchopneumonia	3 days
Due to: Bronchogenic carcinoma	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Bronchogenic carcinoma with metastasis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. L. FLECK, Lt. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 1-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1/24/47

2-25

2-2160-2-10

We 2497

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

472 00748

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49 days

Hospital, institution, or street address where death occurred
Wash. San + Hosp. Takoma Park Md.

How long in hospital or institution? 49 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County

City or town Rollins Fork, Virginia
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Mr. Everett F. Trigger.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife Mrs. Bessie Trigger.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 31 - 1899.

8. AGE:

Years	Months	Days	If less than one day
47	4	7	..... hrs. ..... min.

9. Birthplace King George Co. Virginia
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farmer.

FATHER
12. Name Mr. Charles Brown Trigger
13. Birthplace King Geo. Co Virginia

MOTHER
14. Maiden name Sarah Alice Morgan
15. Birthplace Westmoreland Co. Va.

16. Informant Wash. San + Hosp records.
Address Takoma Park Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Jan. 7 1947
(month) (day) (year)

Cemetery or crematory Harmony

Location Washington, D.C.

18. Funeral director James T Ryan Inc.
Address 317 Pa Ave S.E.

19. Jan 7 1947 J. Wilmer Dodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1947, at 10:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 1946, to Jan 7 1947
and that I last saw h.e alive on Jan 7 1947

Immediate cause of death	DURATION
Bronchopneumonia	1 day
Due to	
Due to	
Other conditions Carcinoma of Lung, liver and spine (Include pregnancy within 3 months of death)	2 months

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bruce Benjamin MD
M. D. or other

Address Bethesda 14, Md Date signed 1/7/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00749

CERTIFICATE OF DEATH

Reg. Diat. No. 2130

1. PLACE OF DEATH:
County: Montgomery
City or town: Seneca
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 63 yrs.
Hospital, institution, or street address where death occurred:
Seneca, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Seneca
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: SARAH KATHERINE VIOLETTE

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband: Alfred Lee Violette
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1861

8. AGE: Years	Months	Days	If less than one day
85	10	3	hrs. min.

9. Birthplace: Hillsboro, Louden Co., Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Henry W. Everhart
13. Birthplace: Louden Co., Va.
MOTHER 14. Maiden name: Sarah Thomas Stiles
15. Birthplace: Montg. Co., Md.
16. Informant: Mrs. Bessie Olson
Address: 700 Dale Dr., Silver Spring, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 4, 1947 (month) (day) (year)
Cemetery or crematory: Darnestown Church Cem.
Location: Darnestown, Md.
18. Funeral director: W. Reuben Turner
Address: 7557 Wis. Ave., Bethesda, Md.
19. 1-3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 1, 1947, at 8 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1942, to Jan-1- 1947, and that I last saw h[illegible] alive on Dec-28- 1946

Immediate cause of death	DURATION
Senile Insanity	5 yrs
Due to: Cerebral Hemorrhage	2 yrs
Due to: Arterio-sclerosis	5-10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William C. Gillen, M.D. M. D. or other
Address: Gaithersburg, Md. Date signed: 1-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

00750

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1310

Reg. Dist. No. 2230

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Nine and one-half yrs.
Hospital, Institution, or street address where death occurred:
9 Jefferson Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9 Jefferson Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Argalus William Walker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Ada Chatham Walker
6.(c) If alive, give age: 71 years
7. Birth date of deceased (mo., day, yr.): June 16, 1860

8. AGE: Years: 86 | Months: 6 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Hutton Township, Coles Co., Ill. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Building construction

FATHER
12. Name: George Parker Walker
13. Birthplace: Coles County, Illinois

MOTHER
14. Maiden name: Rhoda Jane Cartwright
15. Birthplace: Coles County? Illinois

16. Informant: Mrs Ada C. Walker
Address: 9 Jefferson Ave, Takoma Park 12, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 17, 1947 (month) (day) (year)
Cemetery or crematory: George Wash. Memorial Cem.
Location: Riggs Road, Hyattsville, Md.

18. Funeral director: D. Asbury Walters.
Address: 7315 Carroll Ave. N.W., Takoma Park, D.C.

19. Jan. 17 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12, 1947 at 12:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1941, to Jan. 10 1947
and that I last saw him alive on January 10, 1947

Immediate cause of death	DURATION
Chronic Myocarditis with Cardio-Renal failure.	years
Due to: Arterio sclerosis	"
Due to: Senility	years
Other conditions: Rheumatoid Arthritis	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Wallace U. Mook M.D.
M. D. or other
Address: 805 Carroll Ave., Takoma Park 12, Md. Date signed: 1-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

00751

CERTIFICATE OF DEATH

Reg. Diat. No. 2180

1. PLACE OF DEATH:

County Montgomery Co.,

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Jan. 9, 1947

Hospital, institution, or street address where death occurred:
Suburban Hosp-8600 Old Georgetown Rd.

How long in hospital or institution? Since Jan 9, 47 Bethesda Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Monte

City or town Gaithersberg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walker, Mrs grace M.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
F	W	S

6.(b) Name of husband ~~or wife~~ None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1880

8. AGE: Years	Months	Days	If less than one day
66	11	23	..... hrs. ..... min.

9. Birthplace Gaithersberg, Maryland
(Town, county and state)

10. Usual occupation (Retired) Nurse

11. Industry or business

FATHER 12. Name James Walker

13. Birthplace Gaithersberg, Maryland

MOTHER 14. Maiden name Emma Waters

15. Birthplace Clarksburg, Maryland

16. Informant Mrs. Geo. Darby

Address Gaithersburg. md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16/47 (month) (day) (year)

Cemetery or crematory Forest Oak Cemetery

Location Gaithersburg md.

18. Funeral director Ernest C. Gartner

Address Gaithersburg md.

19. Jan 16 1947 (Date rec'd by registrar) Alfred A. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 January 1947 at 9-25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 January 1947 to 14 January 1947

and that I last saw her alive on 14 January 1947

Immediate cause of death	DURATION
Carcinoma Breast - Metastases, Spine, Pelvis	
Due to	
Due to	
Other conditions Hypertensive Heart Disease	

(Include pregnancy within 3 months of death)

Major findings of operation None except 1945: Date of op. 1945

Autopsy results No autopsy.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Charles R. L. Hally M.D.
M. D. or other

Address 1801 Eye St N.W. Date signed 14 Jan 47

Work P. G.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00752

CERTIFICATE OF DEATH

Reg. Dist. No. 7160

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred:
4634 Hunt Avenue, Chevy Chase, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4634 Hunt Ave. Chevy Chase, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: NONA BURNS WALKER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry Walker deceased
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 28, 1866

8. AGE: Years	Months	Days	If less than one day
80	1	29	..... hrs. ..... min.

9. Birthplace: Heokuk, Iowa (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Micheal Burns
13. Birthplace: Scotland
MOTHER 14. Maiden name: ? Purcelle
15. Birthplace: Ireland
16. Informant: Catherine W. Greenville (Daughter)
Address 4634 Hunt Ave. Chevy Chase, Md.
17. Shipment (Burial, cremation, or removal. Which?) Date thereof 1/28/47 (month) (day) (year)
Cemetery or crematory: St. Marys Cemetery
Location: Hannibal, Missouri
18. Funeral director: Wm Reuben Dunphrey
Address 7557 Wis. Ave. Bethesda, Maryland
19. 1/28 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27, 1947 at 11:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 1946 to Jan. 26 1947 and that I last saw h.. alive on Jan. 26 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to Hypertension	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John A. Brennan M. D. or other
Address 3935-12-NE Dc. Date signed 1/28/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00753

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? six months, 9 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? six months, nine days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 43 Freeman Place
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WALLER, George Washington D.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Elizabeth Waller

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 11, 1901

8. AGE: Years: 45 | Months: 4 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: George Waller
13. Birthplace: Md. dec.

MOTHER
14. Maiden name: Caroline Crosby
15. Birthplace: Md. dec.

16. Informant: wife: Mrs. Elizabeth Waller
Address: 43 Freeman Place, Kensington, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-17-47 (month) (day) (year)

Cemetery or crematory: Parson's Cemetery

Location: Salisbury, Md.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 1-14 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 January 1947, at 5:16 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 July 1946 to 14 Jan 1947 and that I last saw him alive on 14 Jan 1947

Immediate cause of death	DURATION
Carcinoma, Stomach, with metastasis to regional nodes, liver and greater omentum.	
Due to:	
Due to:	
Other conditions: Cachexia, Thrombosis of the ileo-colic artery with infarction, Peritonitis, acute and Bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of the stomach with metastasis to liver and reg. lymph node. Date of op. 10/30/46

Autopsy results: Carcinoma, stomach with metastasis and Thrombosis, ileo-colic artery

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. G. BELL, Capt. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-14-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1/21/47

2-25

2-2160 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

00754

CERTIFICATE OF DEATH

Reg. Dist. No. 7140

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural near Norbeck

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Connecticut County:

City or town: Hartford

(If outside city or town limits, write RURAL and give nearest town)

Street No. 323 Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Egbert Walsh

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James Eugene Walsh

6.(c) If alive, give age: dec. years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1863

8. AGE:

Years	Months	Days	If less than one day
83	—	16	hrs. min.

9. Birthplace: Danbury, Conn. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER

12. Name: Wm. Benedict

13. Birthplace: New York

MOTHER

14. Maiden name: Helen Dickins

15. Birthplace: New York

16. Informant: Mrs. Bernard Bent — daughter.

Address: Manor Club Estates, Rockville, Md.

17. Removal - Burial (Burial, cremation, or removal. Which?) Date thereof 1-7-1947 (month) (day) (year)

Cemetery or crematory: Wooster.

Location: Danbury - Fairfield Co. Conn.

18. Funeral director: Horne & Pumphrey.

Address: Silver Spring - Md.

19. Jan 6 1947 (Date rec'd by registrar) Josephine M Schaeffer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 1947, at 11:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 1946 to Jan. 5 1947 and that I last saw her alive on Dec. 31 1946

	DURATION
Immediate cause of death: Congestive Heart Failure	4 yrs.
Due to: Cardio-Vascular-Renal Disease	
Due to: Senility	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Richard A Foster M. D. (M. D. or other)

Address: Sandy Spring, Md. Date signed 1/5/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00755

940

CERTIFICATE OF DEATH

Reg. Dist. No. 216

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (7002 MacArthur Blvd)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7002 Mc Arthur Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lindsay R Whittaker. **3.(b) Social Security Number** 579-12-2217

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JAN 18 1882

8. AGE: Years	Months	Days	If less than one day
64	11	25	..... hrs. ..... min.

9. Birthplace PULASKI VA
(Town, county, and state)
10. Usual occupation RETIRED
11. Industry or business

FATHER
12. Name GEORGE A WHITTAKER
13. Birthplace GILES COUNTY VA

MOTHER
14. Maiden name LOUISA MAYO
15. Birthplace GILES COUNTY VA

16. Informant MRS RUTH CORBRON
Address 7002 MACARTHUR BLVD

17. Buried Date thereof 1/15/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Old Sweet Springs W. Va
Location
18. Funeral director W. W. Chambers Co.
Address 3072-M-N.W. Wash., D.C.

19. 1/13 1947 Wm E Forbes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13, 1947, at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 1946, to Jan 13 1947
and that I last saw h[illegible] alive on Jan. 12 1947

Immediate cause of death	DURATION
Coronary thrombosis	6 weeks
Due to Coronary arteriosclerosis	3 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert E Mahaffey M.D.
M. D. or other
Address 3323 O St. N.W. Washington D.C. Date signed 1/13/1947

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

00756

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Kensington, Maryland
(if outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 years
Hospital, institution, or street address where death occurred:
40 W. Washington St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Kensington, Maryland
(if outside city or town limits, write RURAL and give nearest town)
Street No. 40 West Washington Street,
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: MRS. ELVA MANNING WRIGHT

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Herbert Wright deceased
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 3, 1867

8. AGE: Years	Months	Days	If less than one day
79	9	4	____ hrs. ____ min.

9. Birthplace: Goshen, Mass.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Augustus A. Manning
13. Birthplace: Mass.

MOTHER
14. Maiden name: Laura Stedman
15. Birthplace: Mass.

16. Informant: Mr. Berkeley Wright, Son
Address: Kensington, Maryland

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 1/9/47 (month) (day) (year)
Cemetery or crematory: Northampton cemetery
Location: Northampton, Massachusetts
18. Funeral director: Wm Reuben Humphreys
Address: Bethesda, Maryland

19. 1/8 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7, 1947, at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936, to Jan 7 1947
and that I last saw h[illegible] alive on Jan 6 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 hrs 15 dys
Due to	
Due to	
Other conditions: Hypertension Heart Disease. (Include pregnancy within 3 months of death)	—

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: J. Marion Burkhead M.D.
M. D. or other
Address: Silver Spring, Md. Date signed 1/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M